PRIOR PARK SCHOOL
GIBRALTAR

PRIOR PARK MEDICAL CENTRE
Day Pupil Medical Card

Please note: It is a condition of acceptance at Prior Park School that this card is completed in full and returned to the School Administrator.

In the interests of your child's safety, we regret that he/she may not be allowed to start at the school until we are in receipt of a completed card.

Pupil's Surname: _____

Pupil's First Names: _____

Known As: _____

Date of Birth: _____

Place of Birth: _____

Home Address: _____

_____

Emergency Contact Telephone Number: _____

Email Address: _____

Please give your consent if you wish your child to be given medicine by the school administrator if he/she becomes ill during the school day. The following non-prescription medication may be used:

Paracetamol 500mgs tablets (over 12 years old) for headache, pain or fever	YES	NO
Ibuprofen 500mgs tablets (over 12 years old) for muscle, joint strains and period pains	YES	NO
Antiseptic Lozenges for sore throats	YES	NO
Cetirizine 10mgs for hay fever	YES	NO
Gaviscon for nausea or indigestion	YES	NO
Simple Linctus for cough	YES	NO

Signed: _____ Date: _____

CONFIDENTIAL MEDICAL INFORMATION

Has your child had any serious illnesses or injuries requiring admission to hospital? YES NO

If YES please give details: _____

Does your child have asthma, diabetes, epilepsy, recurrent fits or any problem which requires DAILY treatment? YES NO

If YES please give details: _____

Please give details of inhalers, injections, creams or medication taken regularly:
Medicine: _____
Dose /Frequency: _____

Does your child have any specific dietary requirements? e.g. food allergies **YES** **NO**
If YES, please give details: _____

Does your child carry an EpiPen? **YES** **NO**

Does your child have any other long term medical, physical or psychological problems including obesity, eating disorders, self-harm or depression? **YES** **NO**
If YES, please give details: _____
_____

Does your child have any other problems that may affect him/her whilst in school or on trips e.g. allergies, hay fever, eczema, travel sickness, migraines, bed wetting, soiling etc? **YES** **NO**
If YES please give details: _____

Is there anything else that you feel we should know that it is relevant to your child's health and/or wellbeing, e.g. history of family illness, bereavement, parental separation, divorce etc? **YES** **NO**
(If you do not wish to write this here, please send a separate letter to the School Administrator)
If YES please give details: _____
_____

In the case of emergency, every effort will be taken to contact you or a named guardian. If you are unable to be contacted, do you agree to the Headmaster, School Administrator or Tutor giving permission for an emergency procedure, when recommended by a Hospital Doctor? **YES** **NO**

Signed: _____ Date: _____

EMERGENCY CONTACTS

1. Name: _____ Contact Tel: _____
2. Name: _____ Contact Tel: _____

Name of Doctor: _____
Doctor Surgery Address: _____
Doctor Telephone: _____