Pupil Medical & Emergency Contact Information

St.Brigid's Catholic Primary School

Pupil FULL Name:			
Date of Birth:		**Religion:**	
Date of Baptism:		**Church of Baptism:**	
Name of Parent/s with responsibility:			
Address:			
Local Authority: *(please circle)*	KNOWSLEY	LIVERPOOL	ST HELENS
Ethnicity:		**Free School Meals:**	Yes / No
Telephone:	HOME:	MOBILE:	
Parent / Carer Daytime Contact NUMBERS:	Home / Work / Mum / Dad		
	Home / Work / Mum / Dad		

Please provide the details of TWO persons to be contacted if ***parents*** *cannot be contacted* ***in the case of an emergency.***

CONTACT 1	NAME:	
	Relationship to child:	
	Address:	
	PHONE number:	
CONTACT 2	NAME:	
	Relationship to child:	
	Address:	
	PHONE number:	

Pupil Medical & Emergency Contact Information

St.Brigid's Catholic Primary School

DOCTOR'S NAME:					
ADDRESS:					
PHONE NUMBER:					
Your child may need emergency treatment in hospital. To ensure that s/he is protected, please provide the following information:					
Please TICK which immunisations your child has received:	**MMR**	**TETANUS**	**POLIO**	**DIPTHERIA**	**WHOOPING COUGH**
Has your child received his / her booster injections?	YES / NO		*Is your child allergic to penicillin?*	YES / NO	
Is s/he allergic to any other medicines?	YES / NO		*If yes, please name them:*		
Does your child have asthma?					
Does s/he use an inhaler?					
Does your child have good eyesight?					
Does your child have good hearing?					
Is your child having treatment for any medical condition?					
If yes, please identify:					
Please give any further information which you think we should know (heart trouble, epilepsy etc.)					

In the event of any medical treatment being required from a medical practitioner, I give permission for the teaching staff to act on my behalf.

*Signed:(Parent / Carer)*_____ *Date:*_____