KIRK MERRINGTON PRIMARY SCHOOL

PARENT/SCHOOL AGREEMENT FOR SCHOOL HEALTH CARE PLAN (ASTHMA)

To be completed by the Child's Parent/Guardian			
Name of child:			Date of Birth:
Address:			
Telephone Number:			
Mobile Number:			
Work Number:			
MEDICAL INFORMATION			
General Practitioner Name:			
General Practitioner Number:			
Regular Treatment to be taken in school time:			
Name of Treatment and/or Device:			
Time to be administered:			
Method of Administration:			
Are there any side effects that the School need to know about?			
Confirm that my child can or cannot administer medication			
Self administration?	Yes	No	* delete as appropriate
CONTACT DETAILS			
Parents Name :			Signed:
Relationship to child:			Date: