PARK SPRING PRIMARY AFTER SCHOOL CLUB

MEDICAL FORM.

NAME OF CHILD .....

MEDICAL CONDITION/ALLERGY

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.....

.....

ACTION REQUIRED

.....

.....

.....

MEDICATION REQUIRED

NAME OF MEDICATION ..... DOSAGE .....

FREQUENCY/TIME ..... DURATION .....

I/WE AGREE TO INFORM AFTER SCHOOL CLUB STAFF OF ANY CHANGES TO ABOVE DETAILS AS AND WHEN THEY OCCUR

SIGNED ..... PARENT/CARER DATE .....

SEEN, AND NOTED, BY MEMBER OF AFTER SCHOOL CLUB STAFF

SIGNED ..... DATE .....