CARSHALTON BOYS SPORTS COLLEGE
Medical Information – 2016/17

DETAILS OF PUPIL

Surname: _____ Forename(s): _____

Address: _____

_____

Date of Birth: _____ Tutor Group: _____

Condition or Illness: _____

Please use reverse of this form should you need to

MEDICATION

Name/Type of Medication (as described on the container): _____

For how long will your son take this medication: _____

Date dispensed: _____

Full Directions for use:

Dosage and method: _____

Timing: _____

Special Precautions: _____

Side Effects: _____

Self Administration: _____

Procedures to take in an Emergency: _____

CONTACT DETAILS

Name: _____ Daytime Telephone No: _____

Relationship to Pupil: _____

Address: _____

AUTHORISED BY

Date: _____ Signature: _____

Relationship to Pupil: _____