

LA PETITE ECOLE BILINGUE

STEWART INTERNATIONAL SCHOOL



MEDICAL FORM			
SURNAME :	FIRST NAME:	DATE OF BIRTH	
Vaccinations:			Date:
Does your child suffer from allergies?			
Is your child asthmatic? Is he/she under medication?		Other medical information?	
I authorise / do not authorise *the school to dispense medication to my child:* <small>Cross the statement that is not relevant</small>		NAME:	
		SIGNATURE:	
NOTE: The school does not take the responsibility to dispense medication to children unless in the case of a chronic illness such as (asthma, epilepsy, diabetes...)			
Non prescription medicines such as fever relief may be administered but only with prior written consent from the parents.			
Do you authorise the school to dispense antiseptic cream on cuts/ grazes?			
Do you authorise the school to dispense arnica on bumps/bruises?			
Do you authorise the school to put plasters on grazes and cuts?			
Doctor's Name:		Doctor's Telephone:	
IN CASE OF EMERGENCY, after contacting you or the emergency contact: I authorise / I do not authorise the school to take my child to hospital:			
<small>* Cross the statement that is not relevant</small>			
	Home	Work	Mobile
Father:			
Mother:			
Nanny:			
Emergency contact:			
Date:	Signature Father		Signature Mother: