ST PATRICK'S RCVA PRIMARY SCHOOL

MEDICAL FORM (ASTHMA/ALLERGY)

NAME:	**DATE OF BIRTH:**
ADDRESS:	
TICK APPROPRIATE: ☐ **ASTHMA** ☐ **ALLERGIC TO:**	
DETAILS OF EMERGENCY CONTACTS (NAME/CONTACT NUMBERS)	
1ST	☎
2ND	☎
3RD	☎

CLINIC/HOSPITAL CONTACT		
NAME:	☎	**BASED AT:**
GENERAL PRACTITIONER (G.P.)		
NAME:	☎	**BASED AT:**

DESCRIBE MEDICAL NEEDS AND GIVE DETAILS OF CHILD'S SYMPTOMS:

DAILY CARE REQUIREMENTS (E.G. BEFORE SPORT/AT LUNCHTIME):

DESCRIBE WHAT CONSTITUTES AN EMERGENCY FOR THE CHILD, AND THE ACTION TO TAKE IF THIS OCCURS
1.
2.
3.
4.
FOLLOW UP CARE: