Change of Details

Student Name: _____

Change of address: _____

(PLEASE MAKE ANY CHANGES TO PHONE OR MOBILE NUMBERS BELOW)

Medical Conditions non-prescription

Please list any medical conditions that your child suffers from that we should be aware of (eg. Asthma, Severe Headaches, Migraine, Allergies etc).

List of medical conditions and their related symptoms:-

Condition	**Symptoms**

I hereby give the school permission to administer the following medication/emergency treatment, to my child, if required, for the above-mentioned condition/s.

Medication/Emergency Treatment	Dosage (if applicable)

Parental Contact

Phone: **Mother**…….. Home: ……..

Work: …….. Mobile: ……

Email: ……..

Phone**: Father**…….. Home: ……...

Work: …….. Mobile: ……

Email: ……..

Emergency Contact – (*other than Parent/Guardian*)

Name: ……..... Relationship: ……

Phone: Home: …….. Work: ……

Mobile: ……..

Name: …… Relationship: ……..

Phone: Home: …… Work: ……

Mobile: ……...

I give permission for the school to call Dr ……

Phone: …….. OR an ambulance in the event of an emergency.

NAME:…… SIGN:…… DATE:……