

**St. Chad’s C.E. (VC) Primary School**

St. Michael Road, Lichfield, Staffordshire WS13 6SN

**Tel: 01543 226080**

**Email:** **office@st-chads-lichfield.staffs.sch.uk**

**Achieve through Belief**

**Wraparound Care Medical Form**

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Group\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Home Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **EMERGENCY CONTACT 1** |
| Name |  |
| Address |  |
| Postcode |  |
| Relationship to child |  |
| Mobile Number |  |
| Home Number |  |

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| --- |
| **EMERGENCY CONTACT 2** |
| Name |  |
| Address |  |
| Postcode |  |
| Relationship to child |  |
| Mobile Number |  |
| Home Number |  |

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| --- |
| **DOCTOR’S DETAILS** |
| Doctors Name |  |
| Doctor’s Address |  |
| Postcode |  |
| Doctor’s Telephone |  |

Does your child have any known Medical problems or additional needs?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please detail any medical needs your child has/medication taken: (If your child needs to take any medication then an additional medication form will need to be completed).

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Does your child have any known allergies or major dislikes (foods or materials)? (an Allergy Management plan will be put in place where required)

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Does your child have any Dietary requirements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_