

Contact Information

Name of Student:

<p>Emergency Contact 1</p> <p>Name:</p> <p>Relationship to child:</p> <p>Address:</p> <p>Telephone number:</p> <p>Mobile number:</p> <p>Email address:</p>	
<p>Emergency Contact 2</p> <p>Name:</p> <p>Relationship to child:</p> <p>Address:</p> <p>Telephone number:</p> <p>Mobile number:</p> <p>Email address:</p>	
<p>G.P</p> <p>Name:</p> <p>Address of Surgery:</p> <p>Telephone Number:</p> <p>Fax Number:</p>	

Medical History:

This is what you should know about my Medical History:

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Does your child currently take any medication?

Yes No

If yes, what medication at what time and any additional information?

My child's medication is in liquid or tablet or tablet form:

Tabet Liquid

Additional information:

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Does your child have any allergies?

Yes No

Additional Information:

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Sensory Issues and Level of Independence/Assistance Required

Toileting

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Bathing / Showering / Washing

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Hair washed

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Brushing teeth

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Dressing and undressing

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Morning Routine:

My child wakes up when at home at by parent/alarm/staff.

Additional Information:

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Evening Routine:

My child goes to bed at

My child sleeps with the light on/off.

My child sleeps for hours.

Additional information e.g. comfort blanket, soft toys.

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