

Confidential Medical Questionnaire

To be completed by person with parental responsibility

Surname:
Forenames:
NHS Number:
Home Address:
Alternative Contact Address for duration of trip, if different from above:

Date of Birth:
Place of Birth:
Home Tel:
Work Tel:
Mobile Tel:
Alternative Tel:

Name and Address of Family Doctor:

Doctor's Tel:
Please give the date of your son/daughter's last vaccination against Tetanus:

Has your son / daughter had any of the following:	
Asthma or Bronchitis	YES / NO
Heart Condition	YES / NO
Fits, Fainting or Blackouts	YES / NO
Severe Headaches	YES / NO
Diabetes	YES / NO
Allergies to any known drugs	YES / NO
Allergies to food, materials, etc	YES / NO
Other illness or disability	YES / NO
Travel Sickness	YES / NO
Currently taking medication	YES / NO

Is your son / daughter receiving any medical or surgical treatment from your family Doctor or Hospital?	YES / NO
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Has your son / daughter been given specific medical advice to follow in emergencies?	YES / NO
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Does your son / daughter have any special dietary needs?	YES / NO
If yes, please specify:	

If the answer to any of the questions was YES please give full details here.
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Parental Consent : MEDICAL

- > I consider my son / daughter to be capable of taking part in the activities outlined in the letter accompanying this medical questionnaire.
- > I have outlined, over the page, any medical information that may be necessary during the visit.
- > In the event of illness or accident, I consent to any necessary medical treatment, which might include the use of anaesthetics.
- > In the event of any illness or medical treatment / condition occurring after the return of this form and prior to the residential visit, I undertake to inform the school.

Signed: (Parent / Person with parental responsibility)

Date:

Data Protection Act 1998

The information given will be kept secure and in accordance with the above Act.