Confidential Medical Questionnaire

To be completed by person with parental responsibility
(PLEASE USE BLACK INK)

Surname:

Forenames:

Date of Birth:

Place of Birth:

NHS Number:

Home Address:

Home Tel:

Work Tel:

Mobile Tel:

Alternative Contact Address for duration of trip, if different from above:

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

Has your son / daughter been given specific medical advice to follow in emergencies? YES / NO

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.

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.