MEDICAL QUESTIONNAIRE (Residentials)

Pupil's Name: ……

Parents' Name & Initials: ……

Home Address: ……

……

Has your child had any of the following:-
(Please delete as appropriate)

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, medication or plasters	YES	NO
Any other allergies e.g. material, food, insect bites etc.	YES	NO
Other illness or disability	YES	NO
Any recent contact with contagious diseases or infections	YES	NO

If the answer to any of these questions if **YES** please give details below or on a separate sheet which should be firmly attached.

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Immunisation Status:

Has your child received vaccination against Tetanus, (included in the pre-school M.M.R.2 booster)	YES	NO
Is your child receiving medical treatment of any kind from either your G.P. or Hospital?	YES	NO
Has your child been given specific medical advice to follow in emergencies?	YES	NO

Doctor's name and telephone number: (see overleaf)

SIGNED:..... Date……
(Parent or Guardian)