



Medical Form

Child's Surname: _____

Child's First Name (s): _____

Doctors Name and Address: _____

Doctors Telephone: _____

- | | Yes | No | |
|---|--------------------------|--------------------------|---------------------------------------|
| 1. Does your child have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | If Yes, please complete medicine form |
| 2. Does your child have any allergies? | <input type="checkbox"/> | <input type="checkbox"/> | If Yes, please list below |
| 3. Is your child taking any medicine? | <input type="checkbox"/> | <input type="checkbox"/> | If Yes, please complete medicine form |
| 4. Does your child ever faint or get dizzy? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Does your child have any other known medical conditions or additional needs? | <input type="checkbox"/> | <input type="checkbox"/> | If Yes, please list below |
| 6. Does your child have any dietary requirements? | <input type="checkbox"/> | <input type="checkbox"/> | If Yes, please list below |
| 7. Can your child swim? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Any other information? | | | |

Parent/Carer emergency contact numbers:

In the event that my child is involved in a serious accident I expect to be contacted immediately on the above telephone numbers.

In the event that my child requires immediate medical treatment before I can get to the hospital I hereby authorise the staff member present to consent to any emergency medical treatment necessary to ensure the health and safety of my child on my behalf.

Signature of parent/carer: _____ Date: ____ / ____ / ____