MEDICAL/DIETARY QUESTIONNAIRE

PUPIL'S NAME _____ D.O.B _____/_____/_____

PARENT'S NAME AND INITIALS _____

HOME ADDRESS _____

_____

TELEPHONE NO. _____

NAME AND ADDRESS OF FAMILY DOCTOR _____

_____

_____

TELEPHONE NO. _____

SCHOOL Maidenbower Junior School

Has your child had any of the following:-

Asthma or Bronchitis	YES	NO
Heart Condition	YES	NO
Fits, fainting or blackouts	YES	NO
Severe Headache	YES	NO
Diabetes	YES	NO
Allergies to any known drugs or medication	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 and infections	YES	NO

If the answer to any of these questions is YES please give details on the reverse of this form.

Immunisation Status

Has your child received vaccination against Tetanus in the last ten years?	YES	NO
Is your child receiving medical treatment of any kind from either your family doctor or hospital?	YES	NO
Has your child been given specific medical advice to follow in emergencies?	YES	NO

If the answer to either of these questions in YES please give the details here: - (including dosage of any medicines/tablets)

Please inform us of any dietary requirements (allergies/intolerances):