MEDICAL FORM

Please complete this Medical Form if you or your child suffer from any medical condition and hand it back to a member of staff. This form should be completed by a Parent or Guardian if the student is under the Age of 18.

PART 1 - Student Details

Gender:

Full Name:

Date of Birth [DD/MM/YYYY]:

Address including Post Code:

Contact Number:

PART 2 - Parent/Guardian Details

Full Name:

_____

Full Address including Post Code:

_____

_____

Contact Number:

_____

PART 3 - Medical History

Do you or your child suffer from any of the following medical conditions? [please circle]

Asthma	Bronchitis	Diabetes
Eczema	Epilepsy	Migraine
Allergies	Visual Difficulty	Hearing Difficulty
Other/Please Specify		

If you have circled any of the conditions above, please give further details in the box below including any medical requirements.

PART 4 - Emergency Contact Details

Please provide details of one alternative contact such as uncle, aunty, family friend etc.

Full Name:
_____

Relationship to Student:
_____

Contact Number:
_____

PART 5 - Signed

Signed by Parent/Guardian:
_____

Signed by Student:
_____

Date [DD/MM/YYYY]:
_____

End of Medical Form