

# Medical Form



Child's Name

Date of Birth

Contact name

Address

Home Tel. No.

Work Tel. No.

Mobile Tel. No

Other contact  
In emergency

Is your child allergic to: antiseptic?

Bee stings or  
Insect bites?

Does your child suffers from any of the following conditions:

Hay fever?

Diabetes?

Asthma?

Epilepsy?

If yes does he carry his own medication?

Please supply details of other allergies/conditions if relevant:

If you wish to provide further information please do so on a second sheet

Name

Date

Relationship to child