APPENDIX B Guidance on information you may wish to acquire in confidence:-

MEDICAL QUESTIONNAIRE

PUPIL'S NAME _____

PARENT'S NAME AND INITIALS _____

HOME ADDRESS _____

_____

TELEPHONE NO. _____ _____

NAME AND ADDRESS OF FAMILY DOCTOR _____

_____

_____

TELEPHONE NO. _____ _____

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 headaches	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 a separate sheet which should be firmly attached:

_____

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 is YES please give the details here:- (including dosage of any medicines/tablets)

SIGNED _____
Parent/Guardian