Additional Medical Information for Children Aged 5 to 16 Years

(Please complete in BLOCK CAPITALS or circle where appropriate)

1. Child's Registration Details (Continued)

Date: / /

Surname: Forename(s):

Place of Birth: Date of Birth: / / Birth Weight:

Current School:

Name & Address of Person/Guardian with Parental Responsibility:

Relationship: Their 'Phone No:

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2. Child's Medical History

Please confirm if your child is allergic to any substances? *Yes / No*

If yes, please give details:

Has your child ever suffered from the following?:

Asthma	*Yes / No*	Measles	*Yes / No*
Chickenpox	*Yes / No*	Mumps	*Yes / No*
Fits	*Yes / No*	Whooping Cough	*Yes / No*
German Measles	*Yes / No*		

Has your child had any serious illnesses or accidents? *Yes / No*

If yes, please give details:

Has your child had any hospital admissions? *Yes / No*

If yes, please give details:

Is there any history of Fits/Epilepsy in the child's parents or siblings? *Yes / No*

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3. Child's Immunisation Details

1st DTP (Pertussis/Diphtheria/Tetanus/Polio) *Yes / No*
2nd DTP (Pertussis/Diphtheria/Tetanus/Polio) *Yes / No*
3rd DTP (Pertussis/Diphtheria/Tetanus/Polio) *Yes / No*

MMR (Measles/Mumps/Rubella)	*Yes / No*	Pre-School Booster	*Yes / No*
Rubella Booster (Girls Only)	*Yes / No*	BCG	*Yes / No*