Medical Form for Seashell Pre-School

Child's Full Name

Date of Birth

M F
Sex

Parent's/Guardian's Name

Parent's/Guardian's Name

Home Phone

Work Phone

Home Phone

Work Phone

Address

Address

Postcode

Postcode

Email Address

Email Address

Medical Details

Doctor's Name

Health Visitor's Name

Telephone Number

Telephone Number

Address

Address

HAS YOUR CHILD EVER SUFFERED FROM THE FOLLOWING:

Chicken Pox? Yes/No Measles? Yes/No German Measles? Yes/No Whooping Cough? Yes/No
Mumps? Yes/No Pneumonia? Yes/No

HAS HE/SHE OR ANY MEMBER OF THE CLOSE FAMILY SUFFERED FROM (Please state who and when):-

TB?

CONVULSIONS?

ECZEMA?

HAYFEVER?

ASTHMA?

PLEASE STATE ANY ALLERGIES (PENICILLIN, PLASTERS ETC)?

Immunisation	When Started	If Completed	Do Not Know
Diphtheria			
Tetanus			
Poliomyelitis			
Whooping Cough			
Smallpox or MMR			

HAS HE/SHE EVER SEEN A SPECIALIST (Please give details, dates and reasons)?

PLEASE GIVE DETAILS OF ANY OTHER INFORMTION THAT WE SHOULD KNOW ABOUT THE CHILD:

FORM OF CONSENT FOR MEDICAL TREATMENT

In the event of an emergency and my child being considered to be in need of medical treatment whilst in the care of Sea-Shell Playgroup, I agree the below named firstaiders should authorise such treatment on my behalf.

JANICE HUNT GILL CLIFFORD TRACY OCKWELL

I understand the above action to only be taken if we were unable to be contacted

Parent's/Guardian's Signature Date

Procedures prohibited by Religion:
(Sign this only is you wish <u>no</u> medical treatment to be given to child)

Parent's/Guardian's Signature Date