



Child Medical History Form

Full Name:	
Date of birth: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	
	Pascode:
Tel no:	Parent/Guardian mob no:
Parent/Guardian email:	
Are you happy for us to contact you by: <input type="checkbox"/> Text <input type="checkbox"/> Phone <input type="checkbox"/> Email <i>(please tick all that apply)</i>	

Doctor's details:

Doctor's name:	Tel no:
Address:	
	Pascode:

Is your child currently: Yes/No Give details *(continue overleaf if necessary)*

Receiving treatment from the doctor?	<input type="checkbox"/>	<input type="checkbox"/>
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Taking medication?	<input type="checkbox"/>	<input type="checkbox"/>
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Is your child currently: Yes/No Give details *(continue overleaf if necessary)*

Allergies to medicines?	<input type="checkbox"/>	<input type="checkbox"/>
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Any serious illness?	<input type="checkbox"/>	<input type="checkbox"/>
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Congenital heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
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Any other congenital condition?	<input type="checkbox"/>	<input type="checkbox"/>
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Parent/Guardian signature _____	Date _____
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