



ST PIRAN'S
Inspiring Confidence

Medical History Report

Name: Form: Date of birth:

Address:

Contact numbers: Home..... Mother's mobile

Father's mobile: Others:

Doctor's Name: Telephone Number:

1 Has he/she had any of the following diseases in the past 6 months? Please provide dates.

Chicken Pox	Measles	Mumps	German Measles	Whooping Cough	Any Others

2 Has he/she any allergies, including plasters, hayfever etc?

Any treatment:

3 Does he/she suffer from asthma? YES/NO (delete as applicable)

Treatment required if yes:

4 Does he/she have any hearing or sight problems?

Sight:
Hearing:

5 Does he/she have any food allergies or dietary requirements?
If yes, Matron and Chef require at least 48 hours' notice to ensure food is available.

6 Has he/she had any other medical or health problems or recent operations we should know about?

7 Immunisation Record

Please give details if known:

Diphtheria _____	Whooping Cough _____	Any other _____
Polio _____	MMR _____	
Tetanus _____	Meningitis _____	

8 Are there any personal circumstances you feel Matron should know about?

Hospital Treatment

In the event of any emergency, parents or guardians will be contacted immediately. If contact cannot be established, it is helpful if parents are prepared to give permission for the school to authorise a general anaesthetic should it be required for treatment. If you are prepared to give this authority, please sign below.

Child's full name:

I give permission for the school to authorise a general anaesthetic

In the event of an emergency operation

Signed:

When treatment of a minor character is required

Signed:

Date: