

**CONFIDENTIAL (When Completed)**

**MEDICAL INFORMATION**

Pupil's Name: \_\_\_\_\_

Has your son/ward ever suffered from any of the following conditions? Please tick YES or NO.

	YES	NO		YES	NO
Severe Headache or Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Travel Sickness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Walking	<input type="checkbox"/>	<input type="checkbox"/>	Any other Medical Condition	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered YES to any of the above please give further details:

\_\_\_\_\_  
\_\_\_\_\_

Is your son/ward currently receiving any medical treatment from a hospital or his own Doctor? if YES please give details:

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES.** Is your son/ward allergic to any MEDICINES, FOODS or INSECT bites/stings? If YES please give details and treatment required.

\_\_\_\_\_  
\_\_\_\_\_

**DIET.** Does your son/ward need to follow a special diet? If YES please give details:

\_\_\_\_\_  
\_\_\_\_\_

**TETANUS VACCINATION.** When did your son/ward last have a tetanus vaccination?

\_\_\_\_/\_\_\_\_/\_\_\_\_

**DENTAL TREATMENT.** (Trips abroad) It is recommended that your son/ward has a dental check and any work needed, completed before commencement of the journey.

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Parent/Guardian)