ANNEX C
Rev May 11

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			Epilepsy		
Asthma			Fainting or Blackouts		
Hay Fever			Vertigo		
Eczema			Travel Sickness		
Heart Condition			Diabetes		
Sleep Walking			Any other Medical Condition		

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)