

CHILDREN (0 – 16)

CURRENT MEDICAL STATUS

Name: _____ Date of birth: _____

Has your child ever suffered from any of the following conditions? Please give details.				
Asthma	Diabetes	High blood pressure	Epilepsy	Stroke
Kidney disease	Heart disease: Please state		Other: Please state	
Has your child had any operations? Please state:				
Has your parent/brother/sister suffered from any of the conditions below? Please give details.				
Asthma	Diabetes	High blood pressure	Epilepsy	Stroke
Kidney disease	Heart disease: Please state:	Cancer : Please state:	Other: Please state	
Please list any medication being taken? Has your child ever reacted to medication and/or immunisation? If yes what medication/immunisation?				
Any allergies – please state				
Is your child living in a smoke free environment: Yes / No				
Child's favourite pastime?				
School				
Immunisations up to date?				

Today's date: _____

This information is for the use of the Medical Staff only

Medtech updated: _____ (Staff use only)