Medical Questionnaire

Please complete in BLOCK CAPITALS and return this form to the Administrator at Kings Kids Christian School.

Surname of Pupil:
First Name/s of Pupil:
Date of Birth:
Home Address:
Home Telephone No:
Name of Father:
Name of Mother:
Father's Work Telephone No:
Mother's Work Telephone No:
Father's Mobile Telephone No:
Mother's Mobile Telephone No:

Please give the name of two friends or relatives who would be willing to collect your child in an emergency if you are absent or unavailable:

Emergency Contact 1 Name: Telephone No:
Emergency Contact 2 Name: Telephone No:

Details of your Child's Doctor Name: Address: Telephone No:
Does your child suffer from any ongoing medical conditions such as diabetes, asthma or epilepsy? Yes/No If Yes, please give details
Has your child ever had any serious illnesses or major operations? Yes/No If Yes, please give details.
Is your child allergic to any medicines such as penicillin? Yes/No If Yes, please give details.
Does your child suffer from any food or other allergies? Yes/No If Yes, please give details.
Is your child on any long-term medication that needs to be given during the day? Yes/No If Yes, please give details. Do you agree to self-administration of this medication by your child whilst at school? Yes/No
Is there any other information of a medical nature that is relevant to his/her attendance and activities at school?

In Case of an Emergency

I authorise the staff of Kings Kids Christian School to give written consent for anaesthetic or surgery if a parent or guardian cannot be contacted.

Parent/Guardian's Signature:
Parent/Guardian's Name:
Relationship to Pupil:
Date: