Child
Medical History Form

Full Name:

Date of birth: / /

Sex: ☐ Male ☐ Female

Address:

Pascode:

Tel no:

Parent/Guardian mob no:

Parent/Guardian email:

Are you happy for us to contact you by: ☐ Text ☐ Phone ☐ Email *(please tick all that apply)*

Doctor's details:

Doctor's name:

Tel no:

Address:

Pascode:

Is your child currently:	**Yes/No**	**Give details** *(continue overleaf if necessary)*
Receiving treatment from the doctor?	☐ ☐	
Taking medication?	☐ ☐	

Is your child currently:	**Yes/No**	**Give details** *(continue overleaf if necessary)*
Allergies to medicines?	☐ ☐	
Any serious illness?	☐ ☐	
Congenital heart condition?	☐ ☐	
Any other congenital condition?	☐ ☐	

Parent/Guardian signature _____ Date _____