Forest School

Medical Information Form

Child's Full Name	
Date of Birth	
Contact name and relationship to child	
Home Address	
Phone numbers	Home Work Mobile
Doctor	Address Phone

Has your child had any of the following?

Illness	**Comment**	**Medication needed Please specify**
Asthma/Bronchitis		
Sight/hearing difficulties		
Heart Condition		
Diabetes		
Epilepsy		
Allergies: e.g. pollen, nuts etc.		
Have they been stung by a wasp or bee? If yes describe their reaction.		
Date of last Tetanus injection.		

Signed: **Date:**