inspire! THE NEW EDUCATION BUSINESS PARTNERSHIP FOR HACKNEY

Medical Questionnaire (Private and Confidential)

Student's Name _____ Tutor Group _____

Parent/Guardian Name _____

Home Address _____

_____

_____

Telephone _____

Family Doctor Name & Address _____

_____

_____

Telephone _____

School _____

Has your child had any of the following: (please circle as appropriate)

Asthma or bronchitis	YES	NO
Heart condition	YES	NO
Fits, fainting or blackouts	YES	NO
Severe headaches	YES	NO
Diabetes	YES	NO
Allergies to any known drugs or medication	YES	NO
Any other allergies, e.g material, food, insect bites etc	YES	NO
Other illness or disability	YES	NO
Any recent contact with contagious diseases and infections	YES	NO

If the answer to any of these questions is **YES**, please give details on a separate sheet which should be firmly attached.

Immunisation Status

Has your child received vaccination against Tetanus in the last five years?	YES	NO
Is your child receiving medical treatment of any kind from either your Family Doctor or Hospital?	YES	NO
Has your child been given specific medical advice to follow in emergencies?	YES	NO

If the answer to any of these questions is **YES**, please give details on a separate sheet (including dosage of any medicines/tablets)

Number of Extra Sheets Attached ……

Signed ……..…… Date ……..……
Parent/Guardian