CONFIDENTIAL MEDICAL INFORMATION FORM

Full Name:
Date of Birth:
Female/Male:

PLEASE ANSWER THE FOLLOWING QUESTIONS	Yes	No
Does your child have asthma? If yes, please ensure your child has their inhaler with them at all sessions. They will not be able to play without this.		
Does your child have epilepsy? If yes, please discuss this further with the Welfare Officer,		
Does your child suffer anaphylactic reactions? If yes, please discuss this further with the Welfare Officer and ensure that an **ALLERGY ACTION PLAN** is completed.		
Has any close member of your child's family (parent, sibling, uncle/aunt etc) suffered a sudden cardiac event under the age of 35? If yes, please discuss this further with the Welfare Officer,		
Does your child have a condition such as Autism, Asperger's or ADHD? If yes, please discuss this further with the Welfare Officer.		
Does your child have another MEDICAL CONDITION (e.g. an allergy), DISABILITY OR SPECIAL NEED? If yes, please describe below and discuss this further with the Welfare Officer.		

Signed……………………………………………………………………………………(PARENT)

Dated ……………………………………………………………

PLEASE NOTE THAT ALL THE INFORMATION IN THIS FORM WILL BE KEPT CONFIDENTIAL AND WILL BE USED ON A NEED TO KNOW BASIS IN ORDER TO SUPPORT YOUR CHILD.