MEDICAL RECORD FORM

Please complete the form in **BLOCK CAPITALS** using **BLUE INK.**

Childs Details	
Forenames:	Middle Name:
Surname:	Class:
Date of Birth:	Age:

Parent / Legal Guardian Details	
First Name:	Surname:
Address:	
City / Town:	Postcode:
Mobile Tel Number:	Home Telephone:

Medical History

Does your child suffer from any of the following medical conditions ? (Please tick below)

- Asthma ☐
- Bronchitis ☐
- Diabetes ☐
- Eczema ☐
- Epilepsy ☐
- Migraine ☐
- Allergies ☐
- Visual Difficulties ☐
- Hearing Difficulties ☐
- Other/Please Specify ☐ .....

If you have selected any of the boxes above, please give further details including any medical/medication requirements whilst at the Madrasah.

Please complete Page 2

Emergency Contact Details
Please provide details of one alternative emergency contact. For e.g. Grandparents, Uncle, Aunts, or a Family Friend who could be contacted in an emergency if you are unavailable.
Emergency Contact
Full Name:
Relationship to Child:
Telephone Number:

Please return the completed Medical form to the Madrasah as soon as possible. Please inform the Madrasah of any health related changes that may affect your child whilst at Madrasah, as well as any changes to personal contact information.