



# CONFIDENTIAL MEDICAL TREATMENT FORM

Name of Child \_\_\_\_\_

Date of Birth \_\_\_\_\_

Contact Names & Telephone Numbers in Case of Emergency

\_\_\_\_\_  
\_\_\_\_\_

Name / Phone number of Family Doctor \_\_\_\_\_

Details of any allergies \_\_\_\_\_

Details of any specific health problems / prescribed medication \_\_\_\_\_

\_\_\_\_\_

Has your child had Measles/Mumps/Chicken Pox etc? Give details.

\_\_\_\_\_

Please also provide child's inoculation details with dates

\_\_\_\_\_

\_\_\_\_\_

Details of any other communicable or infectious diseases including Hepatitis A/  
Hepatitis B /HIV/Ringworm/TB. (Please also include all other family members.)

\_\_\_\_\_

\_\_\_\_\_

If, in the event of an emergency, I/We cannot be contacted, I/We give full permission for my/our child to be taken to a doctor and permit the doctor to administer any medical treatment necessary. The school will make every effort to contact your child's doctor, but reserve the right to use another medical practitioner if yours is not readily available.

Parent/Guardian's Signature \_\_\_\_\_