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.)

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_____

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 _____