The British Academy

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MEDICAL QUESTIONNAIRE

STUDENT NAME:

HOME ADDRESS:

AGE: **DATE OF BIRTH:**

TELEPHONE NUMBER:

EMAIL ADDRESS:

NAME OF PARENT/GUARDIAN:

EMERGENCY TELEPHONE CONTACT:

NAME OF FAMILY DOCTOR;

ADDRESS:

TELEPHONE NUMBER:

BRIEF MEDICAL HISTORY:

MEDICINES CURRENTLY IN USE:

FOOD ALLERGIES:

DRUG ALLERGIES:

SPECIAL NEEDS:

VACCINATION HISTORY:
(Please provide a copy of your child's immunization records)

PLEASE NOTE THAT ANY/ALL INFORMATION GIVEN WILL BE HELD IN THE STRICTEST CONFIDENCE.

REMARKS/OBSERVATIONS: