

## 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:**