HEALTH/MEDICAL INFORMATION:

Form PR3 (B)

Full Name of Child:	Date of Birth:	

DETAILS OF TWO PERSONS WILLING TO BE CONTACTED IN CASE OF EMERGENCY IF PARENT IS NOT AVAILABLE

Name:	Name:
Address:	Address:
Tel No:	Tel No:
Relationship to the child:	Relationship to the child:

DETAILS OF CHILD'S DOCTOR

DETAILS OF ANY OTHER CLINIC/HOSPITAL THAT THE CHILD ATTENDS

Name:	Name:
Address:	Address:
Tel No:	Tel No:

In the event of my child requiring emergency treatment and the headteacher (or his/her representative) being unable to contact me, I give consent for the member of staff accompanying my child to approve the application of any emergency treatment including anaesthetic advised by the medical authorities for the wellbeing of my child.

My child is allergic to
My child suffers from
Please continue overleaf if necessary
Date of my child's last anti-tetanus injection **20**_ _
My child's religion is

SIGNATURE OF PERSON WITH LEGAL RESPONSIBILITY

DATE

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