



**HEALTH/MEDICAL INFORMATION:**

Form PR3 (B)

School:

Full Name of Child:	Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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**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	
	<i>Please continue overleaf if necessary</i>
Date of my child's last anti-tetanus injection	200__
My child's religion is	

SIGNATURE OF PERSON WITH LEGAL RESPONSIBILITY	DATE
<input type="text"/>	<input type="text"/>