Manor Park (CE) First School

Health Form

Child's Surname .... First Name ....

Date of Birth ....

Lives with (name) .... Relationship to Child ....

Address .... Tel (home) ....

.... Tel (mobile) ....

.... Tel (work) ....

In an emergency please contact:

Contact Name .... Tel (home) ....

Relationship to child .... Tel (mobile) ....

.... Tel ....

	Name	Contact Details
Health Visitor		
School Nurse		
Hospital Consultants		
Psychologist		
Social Worker		
Speech Therapist		
Occupational Therapist		
Portage Worker		
Other (please specify)		

Please could you answer the questions below. If you answer yes to any of them please give details in the space underneath.

1. Have you ever been told that your child has an illness, any allergies or any medical condition that we should be aware of? e.g. asthma	Yes
	No
Details:	

2. Does your child take any medicines, inhalers or tablets regularly?	Yes
	No
Details:	

3. Does your child require a special diet?	Yes
	No
Details:	

4. Does your child need any help with personal care i.e. feeding, dressing, toileting?	Yes
	No
Details:	

5. Does your child use any special equipment in their day e.g. wheelchair, splints, hand rails, walking frames, protective helmet, etc.	Yes
	No
Details:	

6. Does your child have difficulties in seeing/reading at a distance or other eye conditions?	Yes
	No
Details:	

7. Does your child have problems hearing?	Yes
	No
Details:	

8. Does your child have speech difficulties?	Yes
	No
Details:	

9. Does your child attend physiotherapy or occupational therapy?	Yes
	No
Details:	

Form completed by (print name) ....

Signature .... Date..

Thank you for completing and returning this form for your child. It will be kept as a confidential record and updated annually