



New Hall School

ASSESSMENT DAY MEDICAL INFORMATION FORM

Candidate's Full Name	
Does your child suffer from any medical condition or disability?	
YES <input type="checkbox"/> NO <input type="checkbox"/>	
If so, please give details including any treatment given	
Does your child suffer from asthma or any allergy/sensitivity? <i>(drugs, food or any other)</i>	
YES <input type="checkbox"/> NO <input type="checkbox"/>	
If so, please give details	
Will your child have any medication in her/his possession?	
YES <input type="checkbox"/> NO <input type="checkbox"/>	
If so, please give details	
Does your child administer this medication herself/himself?	
YES <input type="checkbox"/> NO <input type="checkbox"/>	
If NO, do you authorise an adult to administer this medication?	
YES <input type="checkbox"/> NO <input type="checkbox"/>	
<p>I also agree to authorise members of staff, during the course of the visit, to approve such medical treatment for my child as is deemed necessary in an emergency on the advice of a qualified medical practitioner. I have stated on this form any medical condition/disability from which my child is suffering, together with details of the treatment required.</p>	
Signed:	Date:
Name of Parent/Guardian:	