

MEDICAL INFORMATION
Please fill out all sections

Name and Address:
of family Doctor
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Telephone Number:

Child's Name and NHS Number:.....

Date of last Tetanus Immunisation:.....

Does your child suffer from any of these conditions? If Yes please specify:

<u>Condition</u>	<u>Details</u>	<u>Condition</u>	<u>Details</u>
Asthma Yes/No		Diabetes YES/NO	
Epilepsy Yes/No		Hay Fever Yes/No	
Skin Condition Yes/No		Glandular Fever Yes/No	
Blood Disorders Yes/No		Mobility Problems Yes/No	
Allergies Yes/No		Dietary Requirements Yes/No	

Any other medical concerns, please specify

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Any prescribed medication. Please specify dose, frequency, whether self administered.....

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PHOTOGRAPHY PERMISSION FORM

We would like your permission to photograph your daughter for possible inclusion in school publications, website and other publicity material. The image(s) will remain the property of Junior West District Hockey.

I give/ I do not give my permission. (please delete)

Name of parent/guardian:

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