

**UNDER 16'S MEDICAL QUESTIONNAIRE**

**IDENTIFICATION**

SEEN .....INT.....

NOT SEEN.....INT.....

FULL NAME.....

D.O.B.....

ADDRESS.....

.....

POST CODE.....

TELEPHONE NUMBER.....

**IMMUNISATION DETAILS – PLEASE TICK OR GIVE DATES IF POSSIBLE**

	TRIPLE	POLIO	HIB
FIRST	.....	.....	.....
SECOND	.....	.....	.....
THIRD	.....	.....	.....
MMR	.....	.....	.....
PRE SCHOOL BOOSTER	.....		
RUBELLA	.....		
15 YEAR BOOSTER	.....		

Is your child currently taking any medication? If so, please give details

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Has your child any allergies? If so, please give details.....

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Has your child had any serious illnesses or operations?.....

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Do you have any worries about your child's health or development?.....

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