

## MEDICAL INFORMATION

Child's name:		Surname:	
Nationality:	D.O.B:	Place of Birth:	Sex: M / F
Doctor/Clinic:			Tel:
First Contact in Emergency:			

Name:	Relationship:	Tel:
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<b>Medical History</b> , has your child suffered from any of the following?		
	<b>Yes</b>	<b>No</b>
Diabetes		
Hepatitis		
Urinary Tract Infections		
Eyesight Problems		
Hearing Problems		
Cardiac Problems		
Respiratory Problems		
Orthopaedic Problems		
Any Allergies		

<b>Date of last vaccination for</b>	
Triple Vaccine	
BCG	
HIB(Meningitis)	
Hepatitis	
Other	

Any other serious health problems or any medical information which may benefit your child in an emergency?
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If <b>Yes</b> please provide separate details:	
Signature:	Date:

