Child Record Form

Child’s Details

Child’s Name:
Date of Birth:
Child’s Preferred Name: *(if different to above)*

Parent’s Details

Mother’s Name:
Mother's Email:
Mother's Work No:
Mother's Mobile No:
Father's Name:
Father's Email:
Father's Work No:
Father’s Mobile No:
Address:

School Details

Child's School:

Head Teacher:

Form Teacher:

School Tel No:

Doctor's Details

Doctor's Name:

Surgery Name:

Doctor's Tel No:

Emergency Contact's Details

Contact: (1)

Home Tel No:

Mobile Tel No:

Relationship to Child:

Contact: (2)

Home Tel No:

Mobile Tel No:

Relationship to Child:

Medical History

Has your child been fully immunised against: (*Please circle correct answer)*

Diphtheria?	Yes/No
Whooping Cough?	Yes/No
Tetanus?	Yes/No
Polio?	Yes/No
Measles:	Yes/No
Mumps?	Yes/No
Rubella?	Yes/No
Hib Meningitis?	Yes/No
Has your child had Chickenpox?	Yes/No

Important Information

Does your child have any: (*Please circle correct answer)*

Allergies?	Yes/No
Special Diet?	Yes/No
Health Problems?	Yes/No
Childhood Illnesses?	Yes/No
Medical Conditions?	Yes/No
Any other important information?	Yes/No

If the answer to any of the above was yes, then please give details:

Please state religion if applicable:

What is your Childs first spoken language:

Any other languages:

Please disclose any other information about your child that may be useful for us to know:

Please Sign

Parent/Carers Name:

Parent/Carers Signature:

Date: