



**GLEBE HOUSE
SCHOOL**

Child's Health and Emergency Information Record
Private and Confidential

Child's name:Date of Birth:

Please circle if your child has had any of the following:

Chicken Pox German Measles Whooping Cough Diphtheria
Scarlett Fever Measles Poliomyelitis

Has your child been immunised against all infectious diseases recommended by your doctor:

Yes / No If No please list those not immunised against:

Person(s) to contact if Parent(s) unavailable:

Name: Relationship to Child:

Address:

..... Post Code: Telephone:

In the event that I cannot be contacted, I hereby give permission for my child to receive any necessary emergency medical care or treatment.

I understand that every effort will be made to contact me before such action is taken.

Signature of Parent: Date:

Medical History (Please give details of any additional allergies, medical conditions, distinguishing marks, illnesses or food/drinks your child can not eat below:)

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Name, address & telephone no: of G.P and Health Visitor.

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N.B.

If parents are divorced who has parental responsibility for the child/ren Mother / Father
Does the other parent have legal access to your child Yes/No (Please delete as appropriate)