

Taster Day Medical & Dietary Form

1 Details of Child

Please complete in capitals

Surname: _____ Date of Birth: _____
 Forename(s): _____ Nationality: _____
 Preferred Name: _____ Gender: (M / F)

Taster Day:	Nursery	<input type="checkbox"/>	Year 1	<input type="checkbox"/>	Year 4	<input type="checkbox"/>
	Pre-School	<input type="checkbox"/>	Year 2	<input type="checkbox"/>	Year 5	<input type="checkbox"/>
	Reception	<input type="checkbox"/>	Year 3	<input type="checkbox"/>	Year 6	<input type="checkbox"/>

Please tick ✓

2 Child's Medical Information

Doctor's Name: _____
 Address: _____
 Post Code: _____ Tel: _____
 Medical Condition: _____
 Allergies: _____
 Medication: _____
 Dietary Requirements: _____
 Other Information: _____

Are your child's immunisation injections up to date?

Yes:
 No:

Please tick ✓

Can plasters be used on your child?

Yes:
 No:

Please tick ✓

I hereby authorise any members of staff of the school to act as *loco parentis* to give consent to such medical treatment as is considered necessary for my child by a qualified medical practitioner.

Yes:
 No:

Please tick ✓

3 Parent(s)/Carers(s) Signature

Signed: _____ Dated: _____
 Parent/Carer