YATE TRI-STARS

Childs Name:	Age:	DOB:
Date form is completed:		
Parent/ Carer Details:	Address:	Contact Numbers Home: Mobile:
Emergency Contact Number 1. 2. 3.	Emergency Contact Numbers Home: Mobile: Home: Mobile: Home: Mobile:	Relationship of emergency contact to child
Name of Doctor:	Address of Doctor:	Surgery Telephone Number:

Medical Information		
1. Asthma or bronchitis	Yes	No
2. Sight or hearing impairment	Yes	No
3. Heart Condition	Yes	No
4. Fits, Fainting or blackouts	Yes	No
5. Severe Headaches	Yes	No
6. Diabetes	Yes	No
7. Allergies to any known drug	Yes	No
8. Allergies	Yes	No
9. Received surgical treatment (past 6 months)	Yes	No

If the answer to any of the above questions is Yes, please give details below: