

Please read the forms below and complete ONE relevant to you.

MEDICAL FORM (1)
-To be completed by the person with care of the child(ren)-
(Please print using BLOCK letters)

Child(ren)'s Information

Name _____ Date of Birth _____ Male Female

Name _____ Date of Birth _____ Male Female

Name _____ Date of Birth _____ Male Female

Medical information we should know about

Name of person with care of the child(ren) _____

Relationship to child(ren) _____

Address _____

_____ **Post Code** _____

Home Phone _____ **Mobile Phone** _____

Email Address: _____

If required do, we have permission to contact your emergency contact person Yes/No

Emergency contact person _____

Phone No. _____

Signature _____ Date _____

MEDICAL FORM (2)
-To be completed by the person attending contact-
(Please print using BLOCK letters)

Name of person attending contact _____

Name(s) of child(ren) _____

Relationship to child(ren) _____

Address _____

Post Code _____

Home Phone _____ Mobile Phone _____

Email Address: _____

Medical information we should know about:

If required do, we have permission to contact your emergency contact person Yes/No

Emergency contact person _____

Phone No. _____

Signature _____ Date _____