



**FARNHAM
JUNIOR
AMATEUR
OPERATIC
SOCIETY**

MEDICAL FORM

Child's Name: Date of Birth:

Address:

.....Post Code

Tel No: (Home) (Mobile)

Name, address and telephone no. of your GP

..... Telephone No.....

School:

.....

Does your child suffer from any of the following conditions:

	Past Problem	Problem Now	Details
Asthma/bronchitis/wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/eczema/allergies	<input type="checkbox"/>	<input type="checkbox"/>
Ear trouble/poor hearing	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Any illness or medical condition	<input type="checkbox"/>	<input type="checkbox"/>

Does your child have **any** regular medication or injections? Please give details.....

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Please give details of any other health problems so that we will be able to care for your child at rehearsals.....

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Signed Date