# MEDICAL INFORMATION FORM

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|---|---|---|
| Name of child: | | |
| ID number of child: | | |
| Parent/Guardian name: | | |
| Parent/Guardian contact number: | | |
| Contact person and number if parent/guardian is not available: | | |
| Has your child been fully immunised?<br>Please attach a copy of the immunisation card. | Yes | No |
| Does the child suffer from severe allergies?<br>Please explain: | | |
| Medical history if applicable: | | |
| Is your child taking chronic medication? Please explain: | | |
| Name of doctor: | Contact no of doctor: | |
| Medical aid name: | Medical aid no: | |

I _____parent/guardian of

_____ hereby give consent that my child/ward may receive the

necessary first aid treatment and/or be transported by a Riverview staff member to a doctor or hospital in the case of an emergency.

_____ _____ _____

Parent/Guardian (print name) Parent/Guardian signature Date