CONFIDENTIAL

YOUTH HEALTH QUESTIONNAIRE

(please complete in BLOCK CAPITALS)

YOUTH'S NAME ……………………………………………………………………………………

DATE OF BIRTH ……………………………………………………………………………………

NAME OF FAMILY DOCTOR ……………………………………………………………………………

ADDRESS & TELEPHONE NUMBER OF …………………………………………………………………

………

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……………………………………………………………………**TELEPHONE** ………………………………

NATIONAL HEALTH NO ………………………………………………………………………………

DATE OF LAST ANTI-TETANUS ………………………………………………………………………

DOES HE/SHE SUFFER FROM ASTHMA, DIABETES, EPILECTIC FITS OR ANY OTHER ILLNESS OR DISABILITY? IF SO, PLEASE GIVE DETAILS:

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IS HE/SHE ALLERGIC TO ANY MEDICATION ……………………………………………………………

HAS HE/SHE ANY OTHER ALLERGIES (please give details):

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IS HE/SHE UNDERGOING MEDICAL TREATMENT (please give details):

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(FORM REVISED 2007)