Medical Form

PERSONAL INFORMATION

STUDENT NAME:

CHAPERONE NAME:

EMIRATES:

EMAIL ADDRESS:

DATE OF BIRTH:

PHONE NUMBER:

Please tick if your child has any of the following:

Migraine	Dizzy spells
Diabetes	Epilepsy
Colour blindness	Chronic nose bleeds
Heart condition	Asthma

If other please specify:

Is your child currently taking medication?

YES

NO

If YES please state or attach the information.

Is there any information Goals U.A.E. should know to ensure the physical and emotional safety of you/your child?

YES

NO

If YES please state or attach the information.

I will inform Goals U.A.E. staff as soon as possible of any changes in the medical or other circumstances. To be read and signed by parent of child participant.

PARENT NAME

SIGNATURE:

DATE: