



**DEPARTMENT FOR EDUCATION & CHILDREN
THE LICENSING OF CHILDRENS PERFORMANCES
MEDICAL QUESTIONNAIRE**

Full Name of Pupil:

Date of Birth:

Home Address:

.....

Home Telephone No:

Name of Family Doctor:

School:

<p>1. Has he/she had any of the following illnesses?</p> <p>(a) Asthma</p> <p>(b) Epileptic or other fits</p> <p>(c) Diabetes</p> <p>(d) Any other medical condition or disability which you think should be brought to the attention of staff</p>	<p>Please Answer: Yes*/ No</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>2. Does your child have a visual or hearing impairment?</p>	
<p>3. Does your child receive any tablets or medicines on a regular basis?</p>	

* If yes, please give details overleaf including dates and treatments received.

Signed:Parent/Guardian Date:

THIS FORM TO BE RETURNED WITH PART 1 AND 2 OF THE APPLICATION FORM TO EDUCATION WELFARE SECTION DEPARTMENT OF EDUCATION AND CHILDREN BUILDING 2 ST DAVIDS PARK JOBS WELL ROAD CARMARTHEN SA31 3HB



ADRAN ADDYSG A PHLANT TRWYDDED PERFFORMIADAU PLANT HOLIADUR MEDDYGOL

Enw Llawn y Disgybl:

Dyddiad Geni:

Cyfeiriad Geni:

.....

Rhif Ffôn Cartref:

Enw'r Meddyg Teulu:

Ysgol:

1. A yw ef/hi wedi caael unrhyw un o'r canlynol? (a) Asthma (b) Ffitiau epileptig neu ffitiau eraill (c) Clefyd siwgr (d) Unrhyw gyflwr meddygol neu anabledd arall y dylai gael ei ddwyn at sylw'r staff meddygol	Atebwch Ydy*/Nac ydy
2. A oes gan eich plentyn nam ar y golwg neu'r clyw?	
3. A yw'ch plentyn yn derbyn unrhyw dabledi neu feddyginiaeth ar sail rheolaidd?	

- Os ydy, rhowch fanylion drosodd gan gynnwys y dyddiadau a'r driniaeth a dderbyniwyd.

Arwyddwyd: Rhiant/Gwarcheidwad Dyddiad:

Dylid dychwelyd y ffurflen hon Swyddfa Lles Addysg, Adran Addysg & Phlant, Adeilad 2, Parc Dewi Sant, Heol FFynnon Job, Caerfyrddin SA31 3 HB

DETAILS OF ILLNESSES AND TREATMENTS RECEIVED

Illnesses	Dates From - To	Treatments Received

MANYLION AM Y SALWCH A'R DRINIAETH A DDERBYNIWYD

Salwch	Dyddiadau o – hyd	Triniaeth a Dderbyniwyd