

# ACCESS ARRANGEMENTS (MEDICAL INFORMATION)

AA2

Child's Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

To be completed by the General Practitioner:

Have you examined the child:

Yes:

No:

Date of examination: \_\_\_\_\_

Please outline the condition that you consider will impair the expected performance of this child in his/her entrance assessment:

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Is this a pre existing medical condition?

Yes:

No:

How long do you expect this condition to last?

Will further treatment be required before 20th November 2010?

Yes:

No:

In your opinion, how can the Assessment Centre best support this student to minimise the effects of his/her condition as outlined above?

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Do you consent to the information provided on this form being forwarded to the relevant Assessment Centre along with a request for access arrangements to be made?

Yes:

No:

I am satisfied that the information provided on this form is accurate and that all required original documentation is enclosed.

Doctor's Name : (Please print)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

To be completed by the parent/guardian:

Parent/Guardian Name: (Please print)

Signature: \_\_\_\_\_

Medical Practice official stamp: