

# 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 the Entrance Assessment? Yes:  No:

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

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Do you consent to the information 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: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

**To be completed by the parent/guardian:**

Parent/Guardian Name: \_\_\_\_\_  
Signature: \_\_\_\_\_

Medical Practice official stamp:  
(If available)

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