Oaklands Junior School

Headteacher: Mrs H West

RESIDENTIAL TRIP MEDICAL CONSENT FORM

TRIP TO: Osmington Bay **TRIP DATES: 17th – 21st September 2018**

Child's full name: _____

Date of birth: _____

Home Address: _____

_____

Home telephone number including area code: _____

Doctor's name:._____

Surgery address: _____

Surgery telephone number including area code: _____

EMERGENCY CONTACT NAMES AND TEL. NOS. (*Please ensure parents work numbers and mobile phone numbers are given).*

1)_____

2)_____

3)_____

EMERGENCY MEDICAL TREATMENT *(You are **not** obliged to sign this declaration)*

I _____ being the parent/guardian of _____

delegate responsibility for authorising serious emergency medical treatment to the adult(s) in charge of his/her school party. I understand that every effort would be made to contact me before such treatment was authorised.

Signed _____ Date _____

_____

SWIMMING ABILITY

Please indicate your child's swimming ability by ticking the appropriate box below:

Non–swimmer ☐

Water confident (but **cannot** swim 50m) ☐

Can swim 50m ☐

Continued overleaf

MEDICAL NOTES: *If you need more space please attach a separate sheet to this form.*

Does your child suffer from any medical conditions, including travel sickness? YES/NO.
If YES please provide details.

Is your child currently taking any medication or will need to take medication whilst on the trip? YES/NO.
If YES please complete the form below.

Does your child suffer from any food allergies? YES/NO. If YES please provide details.

Does your child suffer from any other allergies? YES/NO. If YES please provide details.

Is your child allergic to any medication, e.g. penicillin? YES/NO. If YES please provide details.

Does your child have any other special needs we should know about, e.g. sleepwalking? YES/NO. If YES please provide details.

MEDICATION

*The school will **not** give your child medicine unless you complete and sign this section of this form and the Headteacher has agreed that the school staff may administer the medication. The Headteacher reserves the right to withdraw this service.*

Name/type of medication (as described on the container) _____

For how long will your child take this medication? Start: _____ Finish:_____

Full directions for use:
Dosage: _____

Method: _____

Timing: _____

Self-administration: YES ☐ NO ☐

- **I understand that I must deliver the medicine personally to an agreed member of staff and accept that this is a service which the school is not obliged to undertake.**
- **The medication will be clearly labelled with my child's name and the dosage to be administered. Please ensure the medication is within its use-by-date.**

Signed _____ Date _____
