Oaklands Junior School

Headteacher: Mrs H West

RESIDENTIAL TRIP MEDICAL CONSENT FORM

TRIP TO: UFTON COURT **TRIP DATE: MARCH 2019**

Child's full name: _____

Date of birth: _____ National Health No.: (If known): _____

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 _____

_____

MEDICAL INFORMATION:

Please use this page to tell us about any current medical treatments, allergies, special needs (e.g. dietary information, foam pillows, etc.) or any other helpful information about your child.

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

Is your child currently taking any medication? YES/NO. If YES please complete the table overleaf. *Please include details of travel sickness tablets given prior to coming to school on the day of travel to Ufton Court.*

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

MEDICATION

Child's Name: _____ Class: _____

*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 of Medication	Dosage	Timing	Method of Administration	Self-Administration Yes/No

- **I understand that I must deliver all medicines personally to a 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. Please ensure the medication is within its use-by-date.**

Signed: _____ Date: _____

Printed Name: _____ Relationship to Child: _____