Oaklands Junior School

Headteacher: Mrs H West

RESIDENTIAL TRIP MEDICAL CONSENT FORM

TRIP TO: Osmington Bay **TRIP DATES: 23rd – 27th September 2019**

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 ☐

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 Osmington Bay.

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: ______________________________________