Medical Information- RETURN HARD COPY TO SCHOOL

Name of Child_____D.O.B_____

We will have some medical supplies for the children in case of minor ailments, but need your permission to administer it. Please tick and sign the rest of this form as necessary.

Paracetamol ☐

Ibuprofen (for injuries) ☐

Cough Mixture ☐

Throat pastilles ☐

Milk of Magnesia (or equivalent for upset stomachs) ☐

Imodium (or equivalent for diarrhea) ☐

Aftersun/sunscreen ☐

Insect repellant ☐

Please provide any details of any **allergies** or **dietary** problems you think might be relevant information for this trip.

_____
_____
_____

I agree to the above being administered to my child if required. If we have concerns with regards to the health of your children we will contact you within 24 hours.

Signed _____Parent/guardian

I agree to the accompanying staff to act on my behalf in giving permission for the necessary medical/dental treatment to be given to my child should it be required.

Signed _____Parent/guardian

North Tyneside Council

EVF4

Parental Consent

to be distributed with an information sheet giving full details of the visit)

School/Group: _____

1. Details of visit to: _____

From: _____ Date/Time: _____ To: _____ Date/Time: _____

I agree to _____ (name) _____ Date Of Birth taking part in this visit and have read the information sheet. I agree

to _____'s participation in the activities described. I acknowledge the need

for _____ to behave responsibly.

2. Medical information about your child

a. Any conditions requiring medical treatment, including medication? YES/NO
If YES, please give brief details:

_____

_____

_____

b. Please outline any special dietary requirements of your child and the type of pain/flu relief medication your child may be given if necessary:

Dietary Requirements	Medical Needs

For residential visits and exchanges only

c. To the best of your knowledge, has your son/daughter been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be contagious or infectious? YES/NO

If YES, please give brief details:

_____

_____

_____

d. Is your son/daughter allergic to any medication? YES/NO

If YES, please specify

_____

_____

_____

e. When did your son/daughter last have a tetanus injection?

_____

I will inform the Group Leader/Head Teacher as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.

2. Declaration

I agree to my son/daughter receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.
I understand the extent and limitations of the insurance cover provided.

Contact telephone numbers:

Work: _____ Home: _____

Home address: _____

_____

Alternative emergency contact:

Name: _____ Tel No: _____

Address: _____

_____

Name of family doctor: Tel No: _____

Address: _____

_____

Signed: _____ Date: _____

Full name (capitals): _____

THIS FORM OR A COPY MUST BE TAKEN BY THE GROUP LEADER ON THE VISIT. A COPY SHOULD BE RETAINED BY THE SCHOOL CONTACT