

St John Plessington Catholic College – Medical Information Form 2016-17

Pupil Name: **Reg:**

PARENTAL/CARER CONSENT AND MEDICAL INFORMATION FORM FOR ALL EDUCATIONAL VISITS, OVERNIGHT STAYS AND HAZARDOUS ACTIVITIES THROUGHOUT THE YEAR

N.B. ALL SECTIONS OF THE FORM SHOULD BE COMPLETED BY THE PARENT/CARER
School/Organisation: St John Plessington Catholic College

Pupil Forename: **Pupil Preferred Surname:**
Pupil Legal Surname:
Reg Group:
Pupil Address:

1. Details of Journey - Journey/visit to all activities and trips during this academic year.
I agree to my son/daughter/ward named above, taking part in all activities.
I acknowledge the need for obedience and responsible behaviour on his/her part.

2. Medical Information

Cross out the 'YES' or 'NO' which does NOT apply.

Does your child suffer from any of the following conditions?

Asthma	YES/NO	Bronchitis	YES/NO
Chest Trouble	YES/NO	Diabetes	YES/NO
Epilepsy	YES/NO	Fainting Attacks	YES/NO
Heart Trouble	YES/NO	Migraine	YES/NO
Raised Blood Pressure	YES/NO	Tuberculosis	YES/NO

If YES please give details:.....
.....

Does your child suffer from any other condition requiring medical treatment, including medication? YES/NO

Medical Condition name.....

Medication name / frequency taken / dosage.....
.....

Is your child allergic to any medication, insect bites, food etc? YES/NO

If YES please give details:.....
.....

To the best of your knowledge, has your child been in contact with any contagious or infectious diseases, or suffered from anything recently, that may become infectious or contagious? YES/NO

If YES please give details:.....
.....

Has your child received a tetanus injection in the last 3 years? YES/NO

Has your child any special dietary requirements? YES/NO

If YES please give details:.....
.....

3. Swimming

Is your child able to swim? YES/NO

If YES, comment upon your child's swimming ability
– cannot swim / beginner / competent / advanced

- .
- .
- .
- .
- .
- .

4. **Emergency Contacts (including family doctor)**

I may be contacted by telephoning the following numbers
(please amend any incorrect details)

Parent/Carer Name:

Home Tel No:

Work Tel No:

Mobile Tel No:

Address:

Medical Practice: **Tel. No:**

Name of family doctor:

5. **Declaration – I understand that:**

- ✓ I undertake to inform the College as soon as possible of any change in the medical circumstances of my child, as well as any changes to contact address/telephone numbers or dietary needs.
- ✓ I agree to my child taking part in any visits and agree to his/her participation to any or all of the activities. I acknowledge the need for obedience and responsible behaviour on his/her part.
- ✓ I understand that the teacher/youth worker in charge of the group will be acting in 'loco parentis' and in the event of an accident I agree to my son/daughter/ward receiving emergency dental, medical or surgical treatment which might include the use of anaesthetics and blood transfusions, as considered necessary by the medical authorities present.
- ✓ I understand the extent and limitations of the insurance cover provided, and that St John Plessington Catholic College is insured in respect of its legal liabilities only, and that there is no personal accident cover or other cover. Accidents may therefore arise for which the St John Plessington Catholic College is not responsible. Parents/Carers/Guardians may wish to obtain suitable insurance to cover such eventualities.
- ✓ I hereby agree to my child participating in routine visits off the school/establishment site. These visits might include typical activities and these visits will normally take place at locations in the UK. I also agree to activities which may be hazardous and involve an overnight stay or may be abroad. If so I will be provided with full information and my specific permission will be sought for any visits beyond those listed above or which could involve commitment to extended journeys, times or expense;
- ✓ Such visits will normally take place within the school/establishment normal hours, but that if, occasionally, they are likely to extend beyond this, adequate advance notice will be given so that I may make appropriate arrangements for my child to return home;
- ✓ All reasonable care will be taken of my son/daughter/ward during the visit;
- ✓ By signing below I agree that, my son/daughter/ ward can be given over the counter, non-prescription 500mg paracetamol, in school following verbal consent from me by telephone. I understand that a qualified first aider would contact me in the event of such a necessity, having assessed the situation. Aspirin and ibuprofen should not be given to a child under 16 and will only be administered in school if prescribed by a medical practitioner. All other medications which are required be taken during the school day should be sent in to school via reception with written instructions for administration and a signed letter of consent.

Pupil Name:..... **Reg:**

Parent/Carer Signature: **Date:**

Parent/Carer Name:

<RECORD END>