ST JOSEPH'S CATHOLIC PRIMARY SCHOOL, MALMESBURY

RESIDENTIAL TRIP MEDICAL CONSENT FORM

PLEASE RETURN THIS COMPLETED FORM TO THE SCHOOL OFFICE. **FAILURE TO DO SO WILL RESULT IN YOUR CHILD BEING EXCLUDED FROM THE RESIDENTIAL.**
THIS MEDICAL FORM WILL BE TAKEN OFF-SITE FOR THE PURPOSE OF THE SPECIFIED TRIP AND WILL BE THE RESPONSIBILITY OF THE CLASS TEACHER FOR THE DURATION OF THE TRIP. IT WILL SUBSEQUENTLY BE SECURELY LOCKED AWAY IN THE SCHOOL OFFICE.

NAME OF CHILD:
CLASS:
RESIDENTIAL TRIP TO:

PARENT/GUARDIAN DETAILS:	
NAME OF PARENT/GUARDIAN:	
HOME ADDRESS AND POSTCODE:	
HOME TELEPHONE NUMBER:	
MOBILE TELEPHONE NUMBER:	
NAME OF EMERGENCY CONTACT:	
EMERGENCY CONTACT TELEPHONE NUMBER (INCL STD):	
ALTERNATIVE EMERGENCY CONTACT & TELEPHONE NUMBER:	

Please Turn Over

DOCTOR'S CONTACT DETAILS:	
NAME OF CHILD'S DOCTOR:	
NAME OF SURGERY & TOWN:	
FULL TELEPHONE NUMBER OF DOCTOR:	

MEDICAL INFORMATION:	
FOOD ALLERGIES OR OTHER SPECIAL DIETARY REQUIREMENTS:	
MEDICINAL ALLERGIES, MEDICAL REQUIREMENTS OR OTHER SPECIAL NEEDS - PLEASE PROVIDE FULL DETAILS OF DOSAGE. THE HEADTEACHER OR GROUP LEADER WILL ADMINISTER ANY MEDICATION THAT MAY BE REQUIRED:	
HAS YOUR CHILD RECEIVED A TETANUS IN THE LAST 5 YEARS?	

ADMINISTRATION OF CALPOL:	
IF YOUR CHILD IS UNWELL AT ALL AND SHORT TERM PAIN RELIEF IS DEEMED TO BE NEEDED, WE REQUEST YOUR CONSENT FOR AN ADULT LEADER TO ADMINISTER THE RECOMMENDED DOSAGE OF CALPOL:	

GENERAL:	
I REQUEST THAT MY SON/DAUGHTER/ WARD IS EXCLUDED FROM THE FOLLOWING:	
ANY OTHER DETAILS YOU MAY WISH TO MAKE THE ORGANISERS AWARE OF:	

DECLARATION:

<u>In signing this document</u>:

 # I have read and fully understand the information relating to the proposed activity.

 # I am satisfied that all reasonable care will be taken for the safety of those participating and that adequate staffing and safety measures have been arranged. I understand the extent and limitation of the insurance cover provided.

 # I consider my son/daughter/ward to be medically fit to participate in the activities outlined and agree to inform you should this situation change between now and the activity date.

 # I agree to my son/daughter/ward receiving medication and any emergency dental, medical or surgical treatment, including anaesthetic, as considered necessary by the medical authorities present.

 # It is advisable that your son/daughter/ward does not bring any expensive electrical items. If they do, they are solely responsible for them – if they bring a mobile phone, it must be switched off at all times during the day. # Under GDPR guidelines, I understand that I can withdraw my consent at any time.

NAME:	
SIGNATURE:	
DATE:	