EDUCATIONAL VISIT MEDICAL INFORMATION

Science Visit to Iceland - April 2020

The information contained on this form will be kept in the strictest confidence

PASSPORT INFORMATION

If you are in the process of renewing your Passport please fill in as much information as you can.

Passport needs renewing. YES/NO

First name.

Middle name.

Last name.

Date of Birth.

Nationality.

Passport number.

Passport expiry date.

MEDICAL INFORMATION

Does your child suffer from any condition requiring treatment? YES / NO
(If YES please give brief details)

Does your child require any medication whilst they are on the trip? YES / NO
(If YES please give brief details)

If so, is the teacher to be responsible to administering the medication? YES / NO
(If YES please give brief details)

To the best of your knowledge, has your son/daughter been in contact with any contagious diseases or suffered from anything in the last four weeks that may become contagious or infectious? YES / NO
(If YES please give brief details)

Does your son/daughter suffer from an allergic reaction? YES / NO

(If YES please give brief details)

Should the teacher responsible supply painkillers (Paracetamol) to your child, if required? YES / NO

Has your son/daughter received a Tetanus injection in the last ten years? YES / NO

Please give details of any other inoculations given in the last five years.

Please outline any special dietary requirements for your child.

I agree to my son/daughter

NAME: ……. FORM: ……..

DATE OF BIRTH: ……..

Taking part in the above mentioned visit and have read the information about the visit, and agree to his/her participation in any or all of the activities described. I acknowledge the need for obedience and responsible behaviour on his/her part.

I understand the extent and limitation of the insurance provided.

I undertake to inform Miss Wing as soon as possible of any change in the medical condition of my child between the date signed and the commencement of the journey.

I agree to my son/daughter receiving emergency medical treatment, including anaesthetic, as considered necessary by the medical authorities present.

SIGNED: …….. (Parent/Carer) DATE: ……..

CONTACT INFORMATION

I may be contacted by telephone on the following numbers:

PARENT/CARER NAME: ……

DAYTIME TEL: …… EVENING TEL: ……..

MY HOME ADDRESS IS: ……..

……..

If **NOT** available at above, please contact:

NAME: …… TELEPHONE NUMBER: ……..

ADDRESS: ……..

……

Name, address & telephone number of family doctor: ……..

……..

Please mention any other information that you consider to be important with regards to the health of your child.