EDUCATIONAL VISIT MEDICAL INFORMATION

COLOMENDY TRIP, KNY - 26-28TH February 2020

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

Pupils Name: ……. Class ……...

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 of 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 The School 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:

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Name, address & telephone number of family doctor:

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