LEASOWES PRIMARY SCHOOL

CONDOVER RESIDENTIAL 2017

MEDICAL INFORMATION & CONSENT FORM

All participants must complete this form. For all participants under 18, this form should be completed by a parent, guardian, or those with parental responsibility. It should not be completed more than 14 days prior to the visit.

Name Of Participant	Date Of Birth	School/Establishment
Participant's Address:		Home telephone Number
Parent/Guardian/Contact Name(s)	Relationship to participant	Contact numbers:
		Home: Work: Mobile Best 24 hour contact number
Participant's Doctors Name	Address	Telephone

Medical Information:

Does the participant suffer from any of the conditions below (Please tick YES or NO)			
	Yes	No	If Yes is ticked, please give details including medication taken
Asthma			
Epilepsy			
Diabetes			
Bedwetting			
Food Allergies			
Medication Allergies			
Other Allergies			
Any condition which may be aggravated by physical activities			
Has the participant suffered from, or been in contact with, any infectious or contagious conditions in the last 4 weeks?			

Please give the approximate date of the participants' last tetanus _____

Will the participant need to bring any medications for treatment during the visit? Yes / No

Details including dosage and times to be taken:

Please ensure all medication that the participant may require during the visit is clearly labelled with the participants name and dosage required and given to the school or establishment staff in charge of the participant throughout the visit. If inhalers are required please check they are full and provide a spare. If Epipens or similar are required please ensure 2 are supplied. If the participant is not confident to take the medication please let school/establishment staff know.

By signing below I consent for the participant to receive, if necessary, the proprietary medicines listed below at the dosage appropriate for their age:

Ailment	Treatment
Nasal Congestion and Sore throats	Decongestant Lozenge (e.g. Tunes)
Headache	Paracetamol, Calpol (or equivalent)
Insect or plant bites or stings	Proprietary cream or spray
Sore Lips	Lip Salve or Vaseline
Sun Protection	Sun Screen/cream

Signature (Person with parental responsibility if participant under 18)	Print Name	Date

The data provided will be used to ensure the appropriate care and treatment of participants. It will be shared with health professionals as required.