ST MARY'S C E PRIMARY SCHOOL

PARENTS CONSENT and MEDICAL FORM

UFTON COURT, GREEN LANE, UFTON NERVET, READING, RG7 4HD

I wish my son/daughter _____(full name) to be allowed to take part in all of the activities described at Ufton Court (6th – 7th / 7th – 8th October 2021)

I have ensured that my child understands that it is important for his/her safety and for the safety of the group that any rules and any instructions given by the staff in charge, are obeyed.

I hereby understand that school staff in charge of the party will take all reasonable care of the young people, but I agree to indemnify Surrey County Council, its employees and agents against all liability for injury, loss to person or persons including death and damage to property, legal expenses and direct consequential losses or damage due to the acts or default of my son/daughter unless the illness, injury or death was due to the negligence of Surrey County Council, its employees or agents.

I consent to any emergency medical treatment necessary during the course of the visit.

I consent to my son/daughter being given a mild painkiller (paracetamol) if considered necessary by the party leader.

Signed _____ Parent/Guardian

Name of parent/guardian _____(block letters please)

Telephone nos. Home:_____ Mob:_____ Work: _____

If not available, please state an alternative contact:

Name _____ Tel home _____ Mob _____

Relationship to child_____

Please indicate if any of the following apply to your child:		
Asthma or Bronchitis	YES	NO
Heart Condition	YES	NO
Fits, fainting or blackouts	YES	NO
Severe Headaches	YES	NO
Diabetes	YES	NO
Allergies to any known drugs or medication	YES	NO
Any other allergies, e.g. material, food, insect bites, etc	YES	NO
Other illness or disability	YES	NO
Sleepwalking	YES	NO
Vegetarian	YES	NO
Bed wetting	YES	NO
Is your child up to date with vaccinations	YES	NO
Is your child receiving medical treatment of any kind from either your Family Doctor or Hospital?	YES	NO
Has your child been given specific medical advice to follow in emergencies?	YES	NO

If the answer to either of these questions is YES or there is ANY OTHER INFORMATION you wish to share, please give details overleaf: (including dosage of any medicines/tablets)

Doctors Name & Practice_____Tel No. _____

This form must be returned to your child's new year 4 class teacher by Monday 6th September

Please tick the appropriate box

- ☐ My child will be responsible for the self-administration of medicines as directed below with supervision.
- ☐ I agree to members of staff administering medicines/providing treatment to my child as directed below.

Name of medicine	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine
Special Instructions:				
Allergies:				
Other prescribed medicines child / young person takes at home:				

I will ensure that the medicine held by the setting has not exceeded its expiry date.

Signed and agreed:
Parent / Guardian

Print Name: _____

Signature: _____ Date: _____/_____/_____