ST MARY'S CofE PRIMARY SCHOOL

RESIDENTIAL MEDICAL FORM

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

I wish for my son/daughter: ____ (full name) to be allowed to take part in all of the activities described at Ufton Court (5th – 6th / 6th – 7th October 2022)

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 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 currently 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 class teacher by Monday 12th 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 by Parent/Guardian;

Print Name: _________________________________

Signature: ___________________________________ Date: _____/_____/_____

Confidently Me Belonging Together Challenged to Contribute