

ST MARY'S CofE PRIMARY SCHOOL
CONSENT AND MEDICAL FORM



Cumulus Outdoors Residential Centre, Cobbler's Lane, Swanage, Dorset, BH19 2PX

I give permission for my son/daughter: _____ to be allowed to take part in all of the activities at **Cumulus Outdoors Residential Centre (1st, 2nd & 3rd March 2023)**

- 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 instructions given by the staff are obeyed.
- I consent to any emergency medical treatment necessary during the course of the visit.
- I consent to staff administering a mild painkiller (paracetamol) to my son/daughter if considered necessary by the party leader.

Name of parent/guardian (Printed): _____

Signed _____ Parent/Guardian

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

If not available, please state an alternative contact:

Name: _____ Tel Home: _____ Mob: _____

Relationship to child: _____

Please circle to 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).

Doctor's Name & Practice: _____ Tel No: _____

Please return this form to your child's class teacher by Monday 20th February 2023

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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: ____/____/____

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