

Year 6 Calshot Residential

STUDENT Confidential Medical Questionnaire

- To be completed by person with parental responsibility

Surname:
Forenames:
NHS Number:
Home Address:
Alternative Contact Address: for duration of trip, if different from above.
Name and Address of family doctor:

Date of Birth:
Place of Birth:

Contact Information:
Home Tel:
Work Tel:
Mobile Tel:

Alternative Tel:

Doctor Contact:
Doctor's Tel:

Please give the date of your son / daughters last vaccination against Tetanus.
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Is your son / daughter receiving any medical or surgical treatment from your family Doctor or Hospital?
<input type="checkbox"/> YES <input type="checkbox"/> NO

Has your son / daughter been given specific medical advice to follow in emergencies?
<input type="checkbox"/> YES <input type="checkbox"/> NO

Has your son / daughter had any of the following?

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| Asthma or Bronchitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Heart Condition | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Fits, Fainting or Blackouts | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Severe Headaches | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Allergies to any known drugs | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Allergies to food, materials etc. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Other illness or disability | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Travel Sickness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Currently taking medication | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Does your son / daughter have any special dietary needs?
<input type="checkbox"/> YES <input type="checkbox"/> NO

Do you give your permission for basic medication e.g. Paracetamol to be given to your son / daughter should the need
<input type="checkbox"/> YES <input type="checkbox"/> NO

If the answer to any of the questions was YES, please give full details here
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Child's Name:.....

If the answer to any of the questions was YES, please give full details here (continue on separate sheet if required):

Please state any other relevant medical information which does not appear else where on this form(continue on separate sheet if required):

SWIMMING ABILITY: Please tick the appropriate box.

Non Swimmer Swims 10m Swims 25m Swims 50 m More than 50m

Parental Consent - MEDICAL

- I consider my son / daughter to be capable of taking part in the activities outlined in the deposit letter.
- I have outlined, over the page, any medical information that may be necessary during visit.
- In the event of illness or accident, I consent to any necessary medical treatment, which might include the use of anaesthetics.

Signed: _____ Date: _____
(Parent / Person with Parental Responsibility)

In the event of any illness or medical treatment / condition occurring after the return of this form and prior to the residential visit. I undertake to inform the school, youth group responsible for the visit.

Signed: _____ Date: _____
(Parent / Person with Parental Responsibility)

Parental Consent – IMAGES/ PHOTOGRAPHS

- I agree to my child having their photograph taken whilst participating in the listed activities.
- I agree to any photographs of the trip, including those which may include my son / daughter, being used in publications promoting the Runways End Outdoor Centre.
- I agree to any photographs of the trip, including those which may include my son/daughter, being used on the World Wide Web to promote the Runways End Outdoor Centre.

Signed: _____ Date: _____
(Parent / Person with Parental Responsibility)

Data Protection Act 1998

The information given will be kept secure and in accordance with the above Act.