



# LODE HEATH SCHOOL

## Medical Information Consent Form

Name of Trip \_\_\_\_\_ Date of Trip \_\_\_\_\_ Form Reg \_\_\_\_\_ Department \_\_\_\_\_

Pupil Surname \_\_\_\_\_ Pupil Forename \_\_\_\_\_

Parent/Guardian Surname \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Tel no: \_\_\_\_\_

Consent for photographs and videos to be taken? \_\_\_\_\_ YES/NO (please circle as appropriate)

Emergency Contact 1 Name \_\_\_\_\_ Telephone No \_\_\_\_\_

Emergency Contact 2 Name \_\_\_\_\_ Telephone No \_\_\_\_\_

Does your child suffer from any of the following medical conditions?					If YES, please state medication below
Asthma	YES		NO		
Hay fever	YES		NO		
Migraines	YES		NO		
Diabetes	YES		NO		
Epilepsy	YES		NO		
Seizures	YES		NO		

Does your child have any allergies? If yes please list them below	If yes, please state medication

Does your child suffer from any other illness or condition if so please state below:	If applicable, please state medication

Is there any other information we should know about your child? Are they attending hospital for treatment, do they have any dietary issues or problems, religious or cultural customs that would prevent your child receiving medical treatment (eg blood transfusion) or safely participating in any particular activity. If yes please give details:

\_\_\_\_\_

In cases of headaches, period pains, brace problems, etc. do you give consent for your child to be given paracetamol?	
Yes	No

**NB: Any medicines that are required to be kept in our medical room should be sent to school in a named container, together with dispensing instructions**

Signed.....Parent/Guardian

Date .....