



Medical/Offsite Activity and Consent Form

(please complete both sides)

Personal Details:

First name of student _____ Surname _____
Tutor Group _____ Age _____ Date of birth _____ Male / Female
Address _____

Post Code _____
Name of next of kin _____
Next of kin address (if different from above) _____

Post Code _____

Contact Details:

Home _____ Work _____
Mobile _____ Email Address: _____

Medical Details:

Name and address of student's doctor _____

Telephone no: _____ NHS no (if known) _____

Has the student had any of the following?

	Yes	No		Yes	No
Asthma or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to any known medication	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies, eg material, food, plasters	<input type="checkbox"/>	<input type="checkbox"/>
Fits, fainting or blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Other illness or disability	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Travel sickness	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Regular medication	<input type="checkbox"/>	<input type="checkbox"/>
			Recent hospital treatment	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to any of these questions is Yes, please give details: _____

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| Does the student have a care plan | <input type="checkbox"/> | <input type="checkbox"/> |
| On an offsite activity, if it is considered necessary, do you agree to mild painkillers (e.g. Paracetamol) being administered | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the student received vaccination against Tetanus in the last 10 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is the student receiving medical or surgical treatment of any kind from either their family doctor or hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the student been given specific medical advice to follow in emergencies? | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer to either of the last two questions is Yes, please give details here (including name and dosage of any medicines/tablets): _____

Please tick the appropriate box:

My child will be responsible for the self-administration of medicines as directed below	
I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of emergency, as staff may consider necessary	
I recognise that school staff are not medically trained	

Name of Medicine	Required Dose	Frequency	Course Finish	Medicine Expiry

Special Instructions	

Other Prescribed Medicines	

All medication should be stored in the medical room with a valid medication consent form, completed by parent/guardian.

Students are not permitted to have medication on their person except for inhalers/epi pens.

This completed form will be used as your child’s medical record during their time at Crofton. It will also be used should your child undertake off-site activities or school trips. Please inform the school immediately of any information changes. Likewise, in the event of any illness or medical condition developing after the return of this form, please inform the school IMMEDIATELY, so that we can amend our student records.

Signed _____(Person with parental responsibility)

Please print name here _____ Date _____