EMERGENCY MEDICAL FORM

SURNAME:_____ Forenames:_____

Tutor Group:_____ Date of Birth:_____ Sex: Male / Female

Current Address: _____Home Tel No: _____

_____

_____

Parent/Guardian 1._____ Daytime Tel: _____

Name/s 2._____ Daytime Tel: _____

24 Hour Emergency Contacts

1st Contact: Name: _____ Tel No: _____

2nd Contact: Name: _____Tel No: _____

Doctor: Name: _____ Tel No: _____

Surgery Address:_____

_____

My child has/has not been actively immunised against tetanus (please give date of immunisation

_____)

Please list any allergies, e.g. penicillin, elastoplast, foods, etc. and any treatment required - if none please state NONE

_____

_____

Vegetarian? Yes/No Special Diet Yes/No (please specify details)

_____

Other _____

Comments:_____

The Doctor has prescribed (as follows) for my child:

Please inform the Teacher in charge of any change to the following at the start of the visit

Name of Drug or Medicine* Frequency/When? Dosage

1._____

2._____

3._____

***All medicines to be administered during the visit MUST BE CLEARLY LABELLED**

I request that the treatment be given, in accordance with the above information, by a responsible member of the school staff who has received any necessary training.

In the event of my child being taken ill or injured during the period of the visit, to the extent that a surgical operation or injection becomes necessary, I authorise the Teacher in charge to sign on my behalf any written consent to operate, as required by the medical authorities. (The Teacher will make all reasonable efforts to contact me first, if at all possible).

Signed: _____ (Parent/Guardian) Date: _____