

# Offsite Visits – Personal and Medical Information and Consent Form (C3)

8782193 - Year 10 Geography Visit - MLL

### **INFORMATION FOR PARENTS/GUARDIANS/CARERS**

Please complete the questions below and sign the consent. The personal and medical information requested is vital to ensure that appropriate care and support is available for each child. Please consult your family doctor if you are unsure about the suitability of a visit. Medical conditions will not necessarily exclude any child from participating in activities, but leaders should be made aware of anything that might affect the safety/welfare of this child or others in the group.

| PERSONAL DETAILS   |  |                                   |                                    |   |        |  |  |
|--------------------|--|-----------------------------------|------------------------------------|---|--------|--|--|
| STUDENT            |  | PARENT/GUARDIAN/CARER INFORMATION |                                    |   |        |  |  |
| Surname            |  | Name                              |                                    |   | Form:  |  |  |
| First Name         |  | Address                           |                                    |   |        |  |  |
| Address Postcode   |  | Postcode                          |                                    |   |        |  |  |
| Posicode           |  |                                   |                                    |   |        |  |  |
|                    |  |                                   | Telephone Numbers                  |   |        |  |  |
| Date of Birth      |  | Day                               | Evening                            | ı | Mobile |  |  |
|                    |  |                                   |                                    |   |        |  |  |
| Doctor             |  | Addition                          | tional Emergency Contact *Required |   |        |  |  |
| Surgery<br>Address |  | Name                              |                                    |   |        |  |  |
|                    |  | Relationship                      |                                    |   |        |  |  |
|                    |  | Address                           |                                    |   |        |  |  |
| Telephone No       |  | Telephone                         |                                    |   |        |  |  |

#### **DIETARY INFORMATION**

If this child has any specific dietary needs (e.g. vegetarian), please give details here:

#### **MEDICAL or SPECIAL NEEDS** Please provide all relevant information which will enable Leaders to safely care for this child (please circle answers): Does this child have any significant allergies (including to medication)? No Yes Does this child have any medical conditions, impairments, or disabilities? No Yes Has this child had any recent significant illnesses or injuries? Yes No If a residential visit, does this child have any night-time tendencies (e.g. Yes No sleepwalking, nightmares, bed-wetting) which might cause him/her concern?

If the answer is "yes" to any of these questions, please give full details below (use an additional sheet if necessary):

## PERSONAL MEDICATION

It is important that this child is accompanied by any medication necessary, and that leaders are fully informed. Please make sure that there is sufficient medication, and that it is clearly labelled.

| Informed. Thease make sure that there is sufficient medication, and that it is clearly labelled. |        |   |                             |  |  |  |
|--|--------|---|-----------------------------|--|--|--|
| Name of Medication   | Dosage | Time and Frequency or circumstances to be | Method of<br>Administration |  |  |  |
|  |        | given                                     | 714                         |  |  |  |

| Please state any special precautions, side effects of  | of medication (if applicable):   |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
|  | , ,  |  |   |  |  |  |  |
|  |  |  |   |  |  |  |  |
| I give my consent for a member of staff to adminis   | ster the above medication  |  |   |  |  |  |  |
| which I will deliver to the Overall Group Leader bef   | ore the visit, together with   | Yes  | No  |  |  |  |  |
| clear labels and instructions. I understand that the   | staff leading the visit are not  |  |   |  |  |  |  |
| qualified medical practitioners, but that they will take   | te reasonable care in the  |  |   |  |  |  |  |
| administration of the medication.  |  |  |   |  |  |  |  |
| I give my consent for this child to self-administer to   | he above medication.   | Yes  | No  |  |  |  |  |
| To the best of your knowledge, has this child been   | in contact with any  |  |   |  |  |  |  |
| contagious or infectious diseases or suffered from   |  | Yes  | No  |  |  |  |  |
| weeks that may be, or become, contagious or infec  | , ,  | 100  | 110   |  |  |  |  |
| If YES, please give brief details:   | ()   |  |   |  |  |  |  |
| ii 120, piedse give brief details.   |  |  |   |  |  |  |  |
| Does this child have up-to-date protection against   | tetanus (normally an injection   | Yes  | No  |  |  |  |  |
| within the past 10 years)?   | THENT BURNS VISITS   |  |   |  |  |  |  |
|  | TMENT DURING VISITS  | oodooboo   | rochoo  |  |  |  |  |
| Young people sometimes need minor medical tre-<br>coughs & colds, insect bites, etc. If necessary, w   |  |  |   |  |  |  |  |
| with the following "off the shelf" products which are  |  |  | aminonto  |  |  |  |  |
| Paracetamol, throat lozenges, cough mixture, ar  | •  |  | ic wipes,   |  |  |  |  |
| hypoallergenic adhesive plasters, witch hazel, inse  |  |  | . ,   |  |  |  |  |
| Please state clearly below if you do not wish this   |  | roducts m  | entioned  |  |  |  |  |
| above (or if other alternatives are acceptable or pre  | eferred instead):  |  |   |  |  |  |  |
|  |  |  |   |  |  |  |  |
| Are you willing for this child to be given these produced  | ucts, if required? (circle answer)   | Yes  | No  |  |  |  |  |
| MAJOR MEDICAL TREATMENT DURING VISITS  |  |  |   |  |  |  |  |
| WIAJON WILDICAL TREA   | TIME TO DOTAIN OF THE TOTAL OF   |  |   |  |  |  |  |
| Do you <b>agree</b> to this child receiving emergency m  |  |  |   |  |  |  |  |
| Do you <b>agree</b> to this child receiving emergency mis considered necessary by the medical authorities  | nedical or dental treatment if it present, and if it has not been  |  |   |  |  |  |  |
| Do you <b>agree</b> to this child receiving emergency magnetic is considered necessary by the medical authorities possible to contact you beforehand? In second  | nedical or dental treatment if it present, and if it has not been such extreme and unlikely  | Yes  | No  |  |  |  |  |
| Do you <b>agree</b> to this child receiving emergency magnetic is considered necessary by the medical authorities possible to contact you beforehand? In scircumstances, the Overall Group Leader would be   | nedical or dental treatment if it present, and if it has not been such extreme and unlikely e authorised on your behalf to   | Yes  | No  |  |  |  |  |
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