SUTTON ST JAMES C.P. SCHOOL

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Head Teacher: Miss Claire Willows

13th March 2017

Dear Parents,

Kingswood Residential – 5-7th June 2017

As the time for your children to go to Kingswood approaches we need to collect and collate some key medical information. It is essential for us to be made aware of any medical conditions and allergies that your child has so that we can ensure that they can be cared for effectively.

Please complete the attached medical form as soon as possible, filling in **all** sections, and return it to school before **Wednesday 22nd March 2017.** If any of the information on the form changes in the time between completion of the form and the visit please keep us up to date and informed. Thank you.

Yours sincerely

Miss C Willows
Headteacher

Sutton St James CP School

PARENTAL CONSENT FORM FOR A SCHOOL VISIT

SCHOOL: Sutton St James CP School

NATURE OF VISIT: Residential visit

1. Details of visit to: Kingswood, West Runton, Norfolk

From: Monday 5th June To: Wednesday 7th June 2017

I agree to _____ (name of child), taking part in this visit and have read the information. I agree to my child's participation in the activities described. I acknowledge the need for **him/her** to behave responsibly.

2. Medical information about your child
Please state

a. Any condition requiring medical treatment, including prescribed medication YES/NO

If YES, please give brief details:

_____

_____

b. Please outline any special dietary requirements of your child (allergies or cultural / religious practices, **not preferences**)

_____

_____

c. To the best of your knowledge, has your son/daughter been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be contagious or infectious? YES/NO

If YES, please give brief details:

_____

_____

d. Is your son/daughter allergic to any medication? YES/NO
If YES, please specify:

_____

e. When did your son/daughter last have a tetanus injection?

_____

Contact telephone numbers: (e.g. Mum, Dad)

Name_____ Relationship to child_____

Work_____ Home_____

Mobile_____

Home Address_____

_____

Name_____ Relationship to child_____

Work_____ Home_____

Mobile_____

Home Address_____

_____

Alternative Emergency Contact: (e.g. Grandparent, Neighbour)

Name_____ Relationship to child_____

Work_____ Home_____

Mobile_____

Home Address_____

_____

Name of Family doctor_____ Tele. Number_____

Address_____

_____

I will inform the Group Leader as soon as possible of any changes in the medical or other circumstances between now and the commencement of the visit.

3. Declaration

- I agree to my son/daughter receiving prescribed medication as instructed or any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

- I give permission for my child to receive an appropriate dose of paracetamol based medication (e.g. Calpol) should it be required in the event of a headache or earache etc.

Signed_____ Date_____

Full Name (capitals)_____