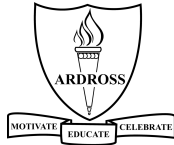


PARENT CONSENT – MEDICAL DETAILS



ARDROSS PRIMARY SCHOOL

STRICTLY CONFIDENTIAL

This information is required for each student participating on the excursion and will assist the school and supervising teachers in the preparation and planning of the excursion.

Student details

Student's name _____ Date of birth _____

Parent/Guardian's full name _____

Address _____ Postcode _____

Telephone N° - Home _____ Telephone N° - Work _____

Telephone N° - Mobile _____

Name of family doctor _____ Telephone N° _____

Medical details

Is your child subject to seizures, fainting, epilepsy, diabetes or any other condition that may affect his or her safety during the excursion.

Yes No Blood Group (if known) _____

If 'yes', please give details:

Is your child allergic to

Penicillin Any other drug Any food Other

Please give details:

Date of last tetanus vaccination _____

Medication

Parents/Guardians are requested to make arrangements with the teacher-in-charge for the safekeeping and handling of medications prior to the excursion.

Is your child presently taking tablets and/or other forms of medication?

Yes No Medication Name _____

Does your child self-administer the medication?

Yes No Medication Dosage and Frequency _____

Other information - Please provide any other information for which the organisers should be aware.

