

**BRINE LEAS SIXTH FORM**

**MEDICAL INFORMATION AND CONSENT FOR EDUCATIONAL VISIT**

**Form C**

Student Name: \_\_\_\_\_ Year : \_\_\_\_ Student Mobile No: \_\_\_\_\_

Subject: \_\_\_\_\_ Visit to: \_\_\_\_\_

**Date of Visit:**

Depart: \_\_\_\_\_ Return: \_\_\_\_\_

**Medical information**

- a) Does your son/daughter have any conditions requiring medical treatment, including medication? YES/NO

If YES, please give brief details:

\_\_\_\_\_

- b) Please outline any food or other allergies and special dietary requirements.

\_\_\_\_\_

- c) Any recent illness or accident staff should be aware of?

\_\_\_\_\_

- e) 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:

\_\_\_\_\_

- f) Is your son/daughter allergic to any medication? YES/NO

If YES, please specify:

\_\_\_\_\_

## Declaration

In the event of a medical emergency I agree for my son/daughter to receive medication as instructed and any of the following (please delete as appropriate) as considered necessary by the medical authorities present

Emergency dental treatment  
Medical treatment  
Surgical treatment  
Anaesthetic  
Blood transfusion

I understand the extent and limitations of the insurance cover provided and agree that my son/daughter must act responsibly throughout the visit.

### Contact telephone numbers:

Please note that personal mobile numbers are for emergencies only and will not be kept on record unless already provided via the data collection sheets

#### Parent/Guardian Contact Details

Name: \_\_\_\_\_

Mobile: \_\_\_\_\_ Relationship: \_\_\_\_\_

#### Alternative telephone number

Daytime: \_\_\_\_\_ Evening: \_\_\_\_\_

#### Alternative emergency contact

Name: \_\_\_\_\_

Mobile: \_\_\_\_\_ Relationship: \_\_\_\_\_

#### Alternative telephone number

Daytime: \_\_\_\_\_ Evening: \_\_\_\_\_

Name of family doctor: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Practice: \_\_\_\_\_

As part of the activities we may take photographs or video footage to use in printed publications, publicity or promotional material including the local press.

Please tick to give your consent

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS FORM OR A COPY MUST BE TAKEN BY THE GROUP LEADER ON THE VISIT. A COPY SHOULD BE RETAINED BY BL6 ADMIN OFFICE.**