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| Child’s name:   | Date of Birth: |
| **First** Emergency Contact Name, relationship to child and contact number: | **Second** Emergency Contact Name, relationship to child and contact number: |
| **GP** name, address and number: | **Dentist** name, address and number: |
| Does your child take any medication? Please state what, and dosage. | Do you give permission for school to administer your child’s medication? YES / NO **Please sign and date.** |
| Does your child have any of the following **dietary allergies**? |
| Celery | Crustaceans  |
| Egg | Fish |
| Gluten | Lupin |
| Milk | Molluscs |
| Mustard | Nuts |
| Peanuts | Sulphur |
| Soybean | Sesame |
| In case of an allergic reaction, and following advice from emergency services, do you give permission for school to administer the school’s central epi-pen? **Please sign and date.**YES / NO | In case of your child feeling unwell, do you give permission for school to administer the school’s central calpol? **Please sign and date.**YES / NO |
| Does your child have any of the following **dietary requirements?** |
| Halal  | Kosher |
| Vegetarian  | Vegan  |
| Does your child have any of the following **medical requirements?** |
| Anaphylaxis  | Asthma \* |
| Diabetes  | Epilepsy  |
| Enuresis (bed wetting) | Other  |
| \*In case of an emergency, and in the absence of their own inhaler, I give permission for my child to use the school’s central reliever inhaler and spacer.**Please sign and date.**YES / NO |
| Any other information that you feel staff should be made aware of relevant to the visit. |
| In addition to the medical information provided above I understand that the staff responsible for the activities will take all reasonable care of participants. I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ delegate responsibility for authorising serious emergency medical treatment to the adult(s) in charge of his/her school party. I understand that every effort would be made to contact me before such treatment was authorised. Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |