

The Harefield Academy

Emergency Contact / Medical Consent Form For Off Site Visits & Activities:

To be returned to Student Services



Trip

Name of Student.....

Emergency Contact Name: Relationship to student:

Emergency Contact Number:

Has your child been in contact with any contagious or infectious diseases or suffered from anything in the past 4 weeks that may be contagious or infectious? (Please tick) Yes No

If yes please advise what:

Approximate date of the student's last Tetanus injection.

Any relevant information concerning your child's health requiring special attention, but which does not prevent him or her taking part should be noted below. Does your son/daughter have? (Please tick)

Allergies Please list:..... Travel Sickness

Diabetes Asthma Epilepsy Eczema Migraine Period Pain

Any Other Condition which requires medication to be continued for this visit/trip

Please Give Details of Condition:.....

Details of Medication:..... Prescribed: Yes No

Dosage:..... Timing:.....

NB: Medicines must be in the original container as dispensed by the pharmacy

In the event of my child displaying symptoms of Asthma, and if their inhaler is not available or is unusable, I consent for my child to receive Ventolin/Salbutamol from an emergency inhaler held by The Academy for such emergencies. Yes No

Please add other relevant medical information, which you feel The Academy needs to know.

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Does your child have any specific dietary needs? Please specify below.

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The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Academy staff administering medicine in accordance with the The Harefield Academy Supporting Students with Medical Conditions Policy. I will inform the Academy immediately, in writing, if there is any change in condition, dosage or frequency of the medication or if the medicine is stopped before/during the trip/visit.

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

Permission given for the above trip.

Signature of Parent/CarerDate.....



Name of child	Tutor Group
Date medicine provided by parent	



Name and strength of medicine	
Quantity received	Expiry date
Quantity returned @ end of course	

Dose and frequency of Medicine

Date			
Time given			
Dose given			
Name of member of staff			
Staff Signature			
Refusal to take (Tick)			
Student signature (if refused)			



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Quantity received	Expiry date
Quantity returned @ end of course	

Dose and frequency of Medicine

Date			
Time given			
Dose given			
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Staff Signature			
Refusal to take (Tick)			
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