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| **PARENT/GUARDIAN DECLARATION**  I have listed any medical or other conditions concerning my child that might affect the duty of care expected during the off-site visit.  I undertake to inform the Party Leader of any changes in the medical or other circumstances of my child before the date of departure.  I have received information about the programme and agree to his/her taking part in all the activities unless otherwise stated.  I agree to indemnify any member of staff against any claim against a member of staff by a third party, directly or indirectly, arising out of any act or fault by my child.  I agree to indemnify any member of staff involved against any costs and expenses reasonably incurred and/or other sums disbursed by a member of staff on behalf of my child during or as a result of the visit.  Signature of parent…………………………………………. Date………………………..  Name…………………………………Relationship to participant……………………… |
| Is your child on any medication? (if yes please give details below, including dosage and frequency) |  |  |
| **If the answer to any of these questions is yes please give details here:** | |
| Has your child been inoculated against TETANUS? | **Yes** | **No** |
| Date of last injection if known: |  |  |
| Do you consider your child to be medically fit now? | **Yes** | **No** |
| **MEDICAL TREATMENT DURING VISITS**  Young people sometimes need minor medical treatment for conditions such as headaches, rashes, pulled muscles, coughs & colds, insect bites etc. With your permission staff will treat these ailments with “off the shelf” products from a chemist. For example the following items are available: Paracetamol, muscle relaxant cream/spray, witch hazel, throat lozenges, petroleum jelly, cough mixture, antiseptic cream, calamine lotion, adhesive plasters, insect bite antihistamine. | |
| **Please indicate if you are willing for your child to be treated with “off the shelf” medication.** | **Yes** | **No** |
| Professional help would be sought for any more serious conditions and we will contact you by telephone. | |
| **Please indicate if you are willing for your child to undergo emergency treatment from a doctor or hospital including anaesthetic and blood transfusion should this be necessary.** | **Yes** | **No** |
| **Procedures to take in an emergency**  **I give my consent\*\*** for a member of staff to administer the above medication which I will deliver to the  Group Leader before the visit, together with clear labels and instructions.  I understand that the staff leading the visit are not qualified medical practitioners but that they will take reasonable  care in the administration of the medication and will endeavour to respond appropriately should emergency  treatment be required.  **I give my consent\*\*** for my child to self-administer the above medication.  **\*\* delete if not applicable.** | | |

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| DIETARY INFORMATION  Does your child have any individual dietary needs (including vegetarian foods)? Please give details here. |

**PROTECT**

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| **INFORMATION FOR PARENTS/GUARDIANS**  Please complete the questions below and sign the consent. The personal and medical information requested is to ensure that a proper duty of care is possible during the residential visits. | | | | | |
| **PERSONAL DETAILS** | | | | | |
| **STUDENT** | | **PARENT/GUARDIAN INFORMATION** | | | |
| **Surname** |  | **Name** |  | | |
| **First Name** |  | **Address** |  | | |
| **Tutor Group** |  |  |
| **Address**  **Postcode** |  | **Postcode** |
|  |  | **Telephone Numbers** | | | |
| **Date of Birth** |  | **Day** | | **Evening** | **Mobile** |
|  |  |  | |  |  |
| **Doctor** |  | **Additional Emergency Contact** | | | |
| **Surgery Address** |  | **Name** | |  | |
|  |  | **Relationship** | |  | |
|  |  | **Address** | |  | |
| **Telephone No** |  | **Telephone** | |  | |
| **NHS Number** |  |  | |  | |
| **E111HC No.** |  | **Expiry Date** | |  | |
| **Passport No.** |  | **Start Date** | |  | |
|  |  | **Expiry Date** | |  | |
| **MEDICAL INFORMATION**  If your child has a medical condition of any sort please discuss with your family doctor before completing the form. Medical conditions would not normally exclude your child from participating in activities. It is important that your child is accompanied by any medication necessary and that we are made aware of this. Please make sure that they have enough medication with them. | | | | | |

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|  | **Please Tick** | |
| **QUESTIONS** | **Yes** | **No** |
| Has your child had any serious illness in the last two months? |  |  |
| Is your child recovering from an accident, injury or fractured bone? |  |  |
| Is your child a sleepwalker? |  |  |
| Does your child suffer from travel sickness? |  |  |
| Does your child have any incontinence problems? |  |  |
| Are there any activities in which your child should not participate? |  |  |
| Does your child have:  Epilepsy or convulsions  Diabetes mellitus  Asthma  Heart Disease  Any allergies |  |  |
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**Consent and Medical Fitness Form for Residential Visits SHS**