Medical Consent Form

(please complete both sides)

First name of student _____ Surname _____

Tutor Group _____ Age _____ Date of birth _____ Male / Female

Address _____

_____

_____ Post Code _____

Name of next of kin _____

Next of kin address (if different from above) _____

_____ Post Code _____

Contact Details:

Name: _____ Relationship to child: _____

Home No: _____ Work No: _____

Mobile No: _____ Email Address: _____

Medical Details:

Name of student's doctor: _____

Address of surgery:_____

Telephone no: _____ NHS no (if known) _____

Has the student had any of the following?

	Yes	No		Yes	No
Asthma or bronchitis	☐	☐	Allergies to any known medication	☐	☐
Heart condition	☐	☐	Other allergies, eg material,food,plasters	☐	☐
Fits, fainting or blackouts	☐	☐	Other illness or disability	☐	☐
Severe headaches	☐	☐	Travel sickness	☐	☐
Diabetes	☐	☐	Regular medication	☐	☐
			Recent hospital treatment	☐	☐

If the answer to any of these questions is Yes, please give details: _____

_____

_____

	Yes	No
Does the student have a care plan?	☐	☐
Can we administer Paracetamol in school?	☐	☐
Has the student received vaccination against Tetanus in the last 10 years?	☐	☐
Is the student receiving medical or surgical treatment of any kind from either their family doctor or hospital?	☐	☐
Has the student been given specific medical advice to follow in emergencies?	☐	☐

If the answer to either of the last two questions is Yes, please give details here (including name and dosage of any medicines/tablets): _____

_____

_____

Please tick the appropriate box:

My child will be responsible for the self-administration of medicines as directed below	
I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of emergency, as staff may consider necessary	

Name of Medicine	Required Dose	Frequency	Course Finish	Medicine Expiry

Special Instructions	

Other Prescribed Medicines	

All medication should be stored in the medical room. Those students on long term medication require a valid medication consent form, completed by parent/guardian.

Students are not permitted to have medication on their person except for inhalers/epi pens.

This completed form will be used as your child's medical record for the next twelve months. It will also be used should your child undertake off-site activities or school trips. Please inform the school immediately of any information changes. Likewise, in the event of any illness or medical condition developing after the return of this form, please inform the school IMMEDIATELY, so that we can amend our student records.

Signed _____(Person with parental responsibility)

Please print name here _____ Date _____