

**St Laurence School**

**Medical Trip Form**

**ACTIVITY LEADERS MUST HAVE A COMPLETED FORM FOR EACH PARTCIPANT IN THEIR POSSESSION FOR THE DURATION OF THE ACTIVITY.**

N.B YOU MAY NOT PARTICIPATE IN THIS ACTIVITY UNLESS THIS FORM IS **FULLY** COMPLETED AND RETURNED. PLEASE COMPLETE AND RETURN BY

**Confidential Information should be returned in an envelope for the attention of Trip Leader.**

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| **Description of Activity**:  **Dates of Activity**: **Activity Leader**:  |

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| **Name of Participant**:……………………………………….**Tutor Group**…………………………………………………………………………......**Address**:…………………………………………………………………………………………………………………………………………………………………………… **Postcode**………………………………………………………………………………………………………………………………..…………….**Date of Birth:**………………..............................................................................................................................................**Home Tel**………………………………………………………**Mobile Tel:**……………………………......................................................... |

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| **Name of Parent/Carer**…………………………………………………………………………………………………………………………………………**Address**:……………………………………………………………………………………………………………………………………………………………..………………………………………………………………...**Postcode**:…………………………….**Home** **Tel**:…………………….......................**Mobile Tel**:………………………………….............................................................................................................................  |

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| **Name of person to contact in an Emergency (if parent/carer unobtainable**)………………………………………………………**Address:**………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..**Postcode**:………………………………………………………………….**Home Tel**:……………………………………………………..................**Mobile Tel:**…………………………………...................................**Work Tel**:……………………………………………………… |

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| **Details of participant’s food allergies or other special dietary needs:** **Vegetarian? Yes No**………………………………………………………………………………………………………………………………………………………………………………………………………………………………………....................................................................................................................... |

**See over**

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| **Details of participant’s food medical allergies, medical requirements/medication taken or other special needs that the activity leader should be aware of**:…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |

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| **RESIDENTIAL TRIPS ONLY;****Does your son/daughter suffer with any of the following**: **Bedwetting**: Details………………………………………………………………………………………………………………………………..**Night terrors**: Details………………………………………………………………………………………………………………………………**Sleep walking**: Details……………………………………………………………………………………………………………………………..... |

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| **Has your son/daughter received a tetanus injection in the last 5 years?** Yes No |

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| **I give permission for the adult in charge to allow my son/daughter to be** **given paracetamol for minor headaches/pain relief.** Yes No  |

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| **I require that my son/daughter be excluded from the following (include any physical limitations)**:……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………. |

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| **Any other details you wish to make the organisers aware of**:..................................................................................……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |

**Your signature below indicates that in the event of your child needing emergency medical treatment under general anaesthetic, a teacher may give consent for that treatment.**

**Please advise the activity leader of any medical problem that arises immediately prior to the visit, especially if this means that a course of medication has to be completed.**

**Signed……………………......................………….. (Parent/Carer)**

**Date…………………………………………………………**