



**PERSONAL AND MEDICAL DETAILS FOR CHILD**  
**Year 4 Sayers Croft Residential Trip 7<sup>th</sup> to 9<sup>th</sup> March 2022**



**CHILD'S PERSONAL DETAILS**

CHILD'S FULL NAME..... DATE OF BIRTH..... Class:.....

**CONTACT DETAILS:**

PARENT/CARER NAME: .....

PARENT/CARER HOME ADDRESS.....

PARENT/CARER TELEPHONE CONTACT NUMBER.....

1.ALTERNATIVE EMERGENCY CONTACT:..... TEL NO:.....

2.ALTERNATIVE EMERGENCY CONTACT:..... TEL NO:.....

**CHILD'S MEDICAL DETAILS:**

NAME & ADDRESS OF FAMILY DOCTOR:.....

.....TELEPHONE NUMBER:.....

Has your child had any of the following (*please circle appropriate answer*):

Asthma or Bronchitis	YES	NO	Fits, fainting or blackouts	YES	NO
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Heart condition	YES	NO	Severe headaches	YES	NO
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Diabetes	YES	NO	Allergies to any known drugs or medication	YES	NO
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Any other allergies, eg material, food, insect bites etc	YES	NO
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Other illness or disability	YES	NO
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Any recent contact with contagious diseases and infections	YES	NO
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If the answer to any of the questions above is YES, please give details:

**CHILD'S ALLERGIES/DIETARY NEEDS:**

Please give details of any allergies your child has (eg. material, animal, insect bites, food):

Please give details of any food that your child **CANNOT** eat due to allergies:

Please give details of any special dietary needs your child has:

Has your child received vaccination against Tetanus?	YES	Date if YES .....	NO
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Is your child receiving medical treatment of any kind from either your Family Doctor or Hospital?	YES *	<i>please give details below</i>	NO
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\* .....

Has your child been given specific medical advice to follow in an emergency?	YES *	<i>please give details below:</i>	NO
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\* .....

**CHILD'S MEDICATION DETAILS - Please complete all questions below:**

***Any medicines that need to be taken during a school journey must be clearly labelled with their name, the type of medicine, expiry date and the dosage instructions and signed in to a member of staff. Please add info on an extra sheet if needed with your child's name clearly at the top.***

**1. Will your child need to be given any medication during this trip? YES\* / NO** If Yes\* please give details below:

- |   |   |
|---|---|
| ❖ Medication .....  | Medication .....  |
| ❖ Reason for taking.....                                      | Reason for taking.....                                      |
| ❖ Dosage.....   | Dosage.....   |
| ❖ Expiry date: .....  | Expiry date: .....  |
| ❖ Will be provided by parent/carer from home <b>Yes /No</b>   | Will be provided by parent/carer from home <b>Yes /No</b>   |
| ❖ <b>OR</b> Already in/to be taken from school <b>Yes /No</b> | <b>OR</b> Already in/to be taken from school <b>Yes /No</b> |

**2. If your child uses an **inhaler** or **epipen** these will be kept with your child's group leader. Please ensure that these medicines are in date and clearly labelled with the child's name and the dosage instructions.**

**a) Does your child use an Inhaler? YES\* / NO** If Yes\* please give details below:

- |   |   |
|---|---|
| ❖ Daytime Inhaler Type: .....                               | Expiry date: .....  |
| ❖ When needed?.....   | Dosage.....   |
| ❖ Night time Inhaler Type: .....                            | Expiry date: .....  |
| ❖ When needed?.....   | Dosage.....   |
| ❖ Will be provided by parent/carer from home <b>YES /NO</b> | <b>OR</b> Already in/to be taken from school <b>YES /NO</b> |

**b) Does your child use an Epipen? YES\* / NO** If Yes\* please give details below:

- |   |   |
|---|---|
| ❖ EPIPEN Type: .....  |   |
| ❖ Expiry date: .....  | Dosage.....   |
| ❖ Will be provided by parent/carer from home <b>YES /NO</b> | <b>OR</b> Already in/to be taken from school <b>YES /NO</b> |

Please also give details of the allergy such as symptoms, severity and whether/when your child had to use an Epipen:

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**3. I give permission for the above to be administered by one of the group leaders and I will ensure that I explain the use and dosage of the medicine in advance of the trip.** YES / NO

**4. I consent to any emergency medical treatment necessary during the course of the visit and sharing my details with relevant medical personnel if required.** YES/ NO

**5. I consent to my child being given Calpol / sting or bite relief cream if needed during the trip.** YES/ NO

**6. My child suffers from travel sickness and will need a travel tablet \_\_\_\_ hours before departure** YES/ NO

**ANY OTHER RELEVANT INFORMATION (please complete if appropriate on an extra sheet & attach):**

Signed.....Parent/Carer

Print name.....Parent/Carer Date.....