Marsh Lane Primary School

MEDICAL CONSENT FORM FOR RESIDENTIAL TRIP

Trip to: Gulliver's Trip date: 2nd July 2025

Child's full name: _____

Date of birth: _____ National Health Number (if known): _____

Home address:_____

_____

Home telephone number (including area code):_____

Doctor's name: _____

Surgery address: _____

Surgery telephone number (including area code): _____

EMERGENCY CONTACT NAMES AND TELEPHONE NUMBERS *(please ensure home numbers, work numbers and mobile phone numbers are given).*

Contact 1 – Name:_____ Relationship to child: _____

Telephone numbers:_____

Contact 2 – Name:_____ Relationship to child: _____

Telephone numbers:_____

Contact 3 – Name:_____ Relationship to child: _____

Telephone numbers:_____

EMERGENCY MEDICAL TREATMENT *(You are **not** obliged to sign this declaration)*

I _____being the parent/guardian of _____

delegate responsibility for authorising serious emergency medical treatment to the adult(s) in charge of his/her school party. I understand that every effort would be made to contact me before such treatment was authorised.

Signed:_____ Date: _____

MEDICAL INFORMATION:

Please use this page to tell us about any current medical treatments, allergies, special needs (e.g. dietary information) or any other helpful information about your child.

1. **Does your child suffer from any medical conditions? YES/NO.** If YES, please provide details below.

2. **Is your child currently taking any medication? YES/NO.** If YES, please complete the table overleaf. *Please include details of travel sickness tablets given prior to coming to school on the day of travel.*

3. **Does your child suffer from any food intolerances/food allergies? YES/NO.** If YES, please provide details below.

4. **Does your child suffer from any other allergies? YES/NO.** If YES, please provide details below.

5. **Is your child allergic to any medication, e.g. penicillin? YES/NO.** If YES, please provide details below.

6. **Does your child have any other special needs we should know about e.g. sleepwalking, bedwetting? YES/NO.** If YES, please provide details below.

MEDICATION

Child's Name: _____ Class: _____

*The school will **not** give your child medicine unless you complete and sign this section of this form and the Headteacher has agreed that the school staff may administer the medication. The Headteacher reserves the right to withdraw this service.*

Name of Medication	Dosage	Timing	Method of Administration	Self-Administration Yes/No

- **I understand that I must deliver all medicines personally to a member of staff and accept that this is a service which the school is not obliged to undertake.**
- **The medication will be clearly labelled with my child's name. Please ensure the medication is within its use-by-date.**

Signed: _____ Date: _____

Printed Name: _____ Relationship to Child: _____