**Educational Visits Personal & Medical Information Form**

**CONFIDENTIAL**

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| **VISIT DETAILS** | | | | | | | | | | | | | | |
| **Description of Activity** | | | | | **Y6 JULY RESIDENTIAL 2022** | | | | | | | | | |
| **Departure and Return Dates** | | | | | | **11TH July 2022** | | | **to** | | | **15th July 2022** | | |
| **Venue** | **MANOR ADVENTURES ABERNANT LAKE HOTEL POWYS WALES LD5 4RR** | | | | | | | | | | | | | |
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| **INFORMATION FOR PARENTS/GUARDIANS/CARERS**  Please complete the questions below and sign the consent. The personal and medical information requested is vital to ensure that appropriate care and support is available for each child. Please consult your family doctor if you are unsure about the suitability of a visit. Medical conditions will not necessarily exclude any child from participating in activities, but the school should be made aware of anything that might affect the safety/welfare of this child or others in the group*.* | | | | | | | | | | | | | | |
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| **PERSONAL DETAILS** | | | | | | | | | | | | | | |
| **Name of Child** | | |  | | | | | **Date of Birth** | | |  | | | |
| **Address** | |  | | | | | | | | | | | | |
|  | | | | | | | | **Postcode** | | |  | | | |
| **Parent(s)/Guardian(s) Name** | | | | | |  | | | | | | | | |
| **Address (if different from above)** | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Telephone Numbers:** | | | | **Day** | | |  | | | | | | | |
|  | | | | **Evening** | | |  | | | | | | | |
|  | | | | **Mobile** | | |  | | | | | | | |
| **Additional Emergency Contact:** | | | | | | | **Name** | | |  | | | | |
|  | | | | | | | **Relationship** | | |  | | | | |
|  | | | | | | | **Telephone Number** | | |  | | | | |
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| **DIETARY INFORMATION**  If this child has any specific dietary needs (e.g. vegetarian), please give details here: | | | | | | | | | | | | | | |
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| **MEDICAL or SPECIAL NEEDS**  **Please provide all relevant information which will enable the Visit Leader to safely care for this child:** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | **Yes** | **No** |
| Does this child have any significant allergies (including to medication)? | | | | | | | | | | | | |  |  |
| Does this child have any medical conditions, impairments, or disabilities? | | | | | | | | | | | | |  |  |
| Has this child had any recent significant illnesses or injuries? | | | | | | | | | | | | |  |  |
| If a residential visit, does this child have any night-time tendencies (e.g. sleepwalking, nightmares, bed-wetting) which might cause him/her concern? | | | | | | | | | | | | |  |  |
| **If the answer is “yes” to any of the above questions, please give full details below (use an additional sheet if necessary):** | | | | | | | | | | | | | | |
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| **PERSONAL MEDICATION**  It is important that this child is accompanied by any medication necessary, and that leaders are fully informed. Please make sure that there is sufficient medication, and that it is clearly labelled. | | | | | | | | | | |
| **Name of medication** | | **Dosage** | **Time and Frequency or circumstances to be given** | | | **Method of Administration** | | | | |
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| Please state any special precautions, or side effects of medication (if applicable): | | | | | | | | | | |
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| **I give my consent** for a member of staff to administer the above medication, which I will deliver to the Visit 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. | | | | | | | | | | |
| **I give my consent\*** for this child to self-administer the above medication. | | | | | | | Yes |  | No |  |
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| To the best of your knowledge, has this child been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be, or become, contagious or infectious? | | | | | | | Yes |  | No |  |
| If yes, please give brief details: | | | | | | | | | | |
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| **Please inform the school should this child be in contact with any infectious illness in the prior to the visit departure date. This includes any close contact with a person that is or suspected of having COVID-19.** | | | | | | | | | | |
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| MINOR MEDICAL TREATMENT  Young people sometimes need minor medical treatment for conditions such as headaches, rashes, coughs & colds, insect bites, etc. If necessary, with your permission, staff will treat these ailments with the following “off the shelf” products which are commonly available from most chemists:  Paracetamol, throat lozenges, cough mixture, antiseptic cream, calamine lotion, antiseptic wipes, hypoallergenic adhesive plasters, witch hazel, insect bite antihistamine, suncream. | | | | | | | | | | |
| Are you willing to allow for this child to be given such products, if required? | | | | | | | Yes |  | No |  |
|  | | | | | | | | | | |
| **EMERGENCY MEDICAL TREATMENT DURING VISITS**  **I consent** to any emergency treatment necessary. I therefore authorise the Visit Leader(s) to sign, on my behalf, any written form of consent required by the hospital authorities should medical treatment (a surgical operation or injection) be deemed necessary and if it has not been possible to contact me beforehand. | | | | | | | | | | |
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| **IF SWIMMING IS INCLUDED:** | | | | | | | | | | |
| Do you give permission allowing your child to swim during this visit? | | | | | | | Yes |  | No |  |
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| **PARENT/CARER DECLARATIONS**   * **I am legally responsible for the care of the child mentioned above.** * **I have listed all relevant medical or other conditions** concerning this child that might affect the duty of care expected during an educational visit. * **I undertake** to inform the Visit Leader/Headteacher (in writing) of any changes in the medical or other circumstances of this child before the date of departure. | | | | | | | | | | |
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| Signature |  | | | Date |  | | | | | |