Year 6 Windmill Hill: June 2019

## *EMERGENCY CONTACT DETAILS*

| CHILD'S FULL NAME: | | | |
|---|---|---|---|
| HOME ADDRESS: | | | |
| CONTACT & PHONE NUMBERS | MOTHER | FATHER | OTHER CONTACT |
| | NAME: | NAME: | NAME: |
| HOME: | | | |
| WORK: | | | |
| MOBILE: | | | |
| DOCTOR'S DETAILS NAME: | | | |
| SURGERY ADDRESS: | | | |
| TELEPHONE NUMBER: | | | |

## *MEDICAL / DIETARY INFORMATION*

**Has your child ever had any of the following?**
**Please answer YES or NO to each.**
**If the answer to any of these is YES, please give full details overleaf.**

| | |
|---|---|
| • asthma or bronchitis | |
| • heart condition | |
| • fits, fainting or blackouts | |
| • severe headaches | |
| • diabetes | |
| • allergies to any known drugs or medication | |
| • any other allergies, e.g. material, food, insect bites, etc. | |
| • other illness or disability | |
| • any recent contact with contagious diseases and infections | |

**If the answer to questions marked with an asterisk is YES, please give full details overleaf.**
**(Please include dosage of any medicines/tablets where relevant).**

| | |
|---|---|
| Has your child received vaccination against tetanus in the last 5 years? | |
| Is your child currently receiving medication of any kind prescribed either by your family doctor or hospital consultant? * | |
| Has your child been given specific medical advice to follow in emergencies? * | |
| Is your child a vegetarian or vegan?* **Please stipulate which overleaf.** | |
| Does your child have specific dietary requirements? * | |
| Does your child suffer from enuresis? (Bed wetting) * | |

**I HEREBY CONSENT FOR MY CHILD TO RECEIVE:**

- Professional medical treatment during the course of their stay, should this be required ☐
- Prescribed medication administered by members of North Downs staff as directed overleaf ☐
- Paracetamol (Calpol), antihistamine or arnica cream should this be required. ☐

***(Please tick boxes to confirm)***

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Signed: ________________________________________ (Parent/Guardian) Date: ______________________

**Instructions re- medicine**

| Name of medicine | Dose | Frequency / times | Expiry date of medicine |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Please note**
Medication must be kept in the container / packet supplied by the pharmacist which states:

- **Name of person**
- **Name of medicine**
- **Strength**
- **Dose / frequency of administration**
- **Date of dispensing**
- **Cautionary advice**
- **Quantity of the medicine**
- **Expiry date (if short dated)**

**Parents / carers are responsible for ensuring medicines do not exceed their expiry date.**

**Specific Dietary Requirements**

**Medical Notes**