

Medical and Emergency Contact Consent Form

This form is to be completed by the person with parental responsibility for the named child.

Date of Camp From _____ To _____

Name of child _____ Date of Birth ____/____/____

Name(s) of Parent / Guardian _____

Authorised emergency contact if parent unattainable _____ Tel. No. _____

Address of Parent / Guardian _____

Tel. Number (Day) _____ (Night) _____

Email _____

General Practitioner NAME _____

NAME & ADDRESS OF PRACTICE _____

Does he / she suffer from:

* Asthma	YES / NO	* Epilepsy	YES / NO
* Migraine	YES / NO	* Diabetes	YES / NO
* Dyslexia	YES / NO	* Hay Fever	YES / NO
* Heart / Lung Disorder	YES / NO	* Bone / Joint Impairment	YES / NO
* Vision / Hearing Defects	YES / NO	* Allergy to Drugs / Food	YES / NO
* Gynaecological Disorders	YES / NO	* Ear, Nose & Throat	YES / NO
* Gastro-intestinal Disorders	YES / NO	* Any skin complaint	YES / NO
* Any other medical Disorder	YES / NO	* Special dietary requirements	YES / NO

Please state insulin medication and detail emergency procedures for hypos on the next page

If yes to any of the above, please specify the nature of the problem

Religion, if applicable to Medical Treatment _____

Does he / she regularly take any form of medication? YES / NO (If so, please detail on next page)

Does he/ she need to carry an adrenaline auto-injector? YES/NO Reason: _____

What type and dose is the adrenaline auto-injector? _____

Are there any current injuries / operations / medical treatments? YES / NO If so, please explain.

Any previous operations, e.g. appendix? YES / NO If so, please explain

Has your child received all expected immunisations including tetanus? YES / NO

If no, please detail what was missed _____

Medical Consent Form

Medicines Administration

Whilst my child is attending camp, I authorise you to give the following medicines to my child in my absence. Please state if your child carries and takes their own supply of medication e.g. asthma inhalers/EPI pen.

All the medicines specified below have been prescribed by a registered and licensed medical practitioner and will be provided in the original packet / box / bottle with the child's name and date of birth clearly marked. I agree that the medicines are necessary for my child, that they will be given without intending harm to the child and I indemnify against any loss or claim associated whatsoever with the administration of the medicines specified below.

Name of medicine	Strength of medicine	How much to give each time	Type (tablet / liquid / inhaler)	When to be given (time of day)	Any other information about this medicine
MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICINES (please note if this box is not completed no medicines will be given. Please state if no known allergies.)					

In the event of my child requiring emergency medical assistance whilst taking part in the camp activities I consent to the disclosure of the information i to medical professionals.

Signature:			
Print Name:		Date:	
Role / Relationship:			