

CONFIDENTIAL



CURDWORTH PRIMARY SCHOOL - MEDICAL CONSENT FORM

Ingestre Hall Residential Trip

Details of the child

Surname:	Forename:
Middle Name:	Chosen Name:
Gender: Male / Female	Date of Birth:
Address:	

Adults with parental responsibility

Full Name	Address	Relationship to Child
	Email: Tel:	
	Email: Tel:	

Additional contacts (i.e. Grandparents, Childminder etc.)

***Please record in order of contact preference**

Full Name	Address	Relationship to Child
	Tel:	
	Tel:	
	Tel:	

Medical Information

Doctor's Name	Practice Address	Telephone Number

Please note below any **physical disability or medical condition** which the school should be aware of e.g. diabetic, glasses worn, allergies etc. Please include details of any medical condition that your child suffers from and any medication your child should take during off-site visits:

In the event of your child needing urgent medical treatment, we will endeavour to contact you, using the contact information you have provided. However, if we are unable to make contact we request your permission to authorise medical/hospital staff to proceed with medical treatment where necessary.

I authorise hospital/medical treatment to be given to this pupil without me being present, in the event of the school being unable to reach any of the contacts given.

Signed _____ Parent/Guardian _____ Date