CONSENT TO MEDICAL TREATMENT

Lynch Hill Enterprise Academy

Name of Pupil ………………………………………. **Date of Birth** ……………………

1. **Medical information about your child**

   Does your child suffer from any conditions requiring medical treatment or medication?

   Yes ☐ No ☐

   If yes please give details:

   ………………………………………………………………………………………………………

   ………………………………………………………………………………………………………

   ………………………………………………………………………………………………………

   Please outline any special dietary requirements of your child and the type of pain/flu relief medication your child may be given if necessary:

   ………………………………………………………………………………………………………

   ………………………………………………………………………………………………………

   ………………………………………………………………………………………………………

   Is your child allergic to any medication or treatment?

   Yes ☐ No ☐

   If yes please give details:

   ………………………………………………………………………………………………………

   ………………………………………………………………………………………………………

   ………………………………………………………………………………………………………

   When was the last time your child received a tetanus injection?

   ………………………………………………………………………………………………………

2. I will inform Lynch Hill Enterprise Academy if my son/daughter been in contact with any contagious or infectious diseases or suffered from anything that may be contagious or infectious in the last four weeks before a residential visit.

3. Does your child have any special dietary requirements?

   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

4. **Declaration**

I understand that my child may leave the school premises for local visits as outlined in the school prospectus and hereby give my consent for my child to participate in such visits.

I also understand that my child may leave the school premises at other times when I will be informed separately by letter and when acknowledgement will be required from me. I give my consent for my child to participate in such visits organised by Lynch Hill Enterprise Academy and I agree to my child's participation in the activities described in the letter relevant to each visit unless I state otherwise on the acknowledgement slip. I acknowledge the need for my child to behave responsibly in line with the Code of Conduct.

I agree to my son/daughter receiving medication as instructed and any urgent dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present. I understand the extent and limitations of the insurance cover provided.
I will inform the Group Leader/Head Teacher as soon as possible of any changes in the medical or other circumstances between now and the commencement of a visit.

Signed: ……………………………………………. **Date:** ………………………………

Full name (capitals): ……………………………………………………………………

Contact telephone numbers:

I may be contacted by telephoning the following numbers:

Work: …………………………………………   Home: ……………………………..….

Home address: …………………………………………………………………...……

……………….……………………………………………………………………...……

If I am not available at above, please contact:

Name: ……………………………………..   Tel No: ……………………………..

Address: ………………………………………………………………………..….

..…………..……………………………………………………………………………

Name and address of family doctor:

Name: ………………………………………… Tel No: ……………………………...

Address: ……………………………………………………………………………..

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This form will be placed on your child's school record and will be used throughout the compulsory schooling of the pupil. If a request is subsequently made for the withdrawal of the form a note or letter to that effect will be placed on the file and the copy of the form will be crossed through stating that the form has been withdrawn and the date on which such withdrawal takes effect.