S H A R M A N S C R O S S J U N I O R S C H O O L
EDUCATIONAL VISIT: FORM OF CONSENT

Name of Child:_____
IN CASE OF EMERGENCY

Do you give accompanying staff, who have First Aid qualifications, the authority to give your child 'simple' treatment:

YES/NO

Does your child suffer from any illness that calls for special attention whilst in York e.g. asthma, diabetes etc. Please indicate:-

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In the unlikely event that medical or surgical treatment becomes necessary we will make every effort to seek further consent from parents before treatment is given. Treatment may be urgent and it may be difficult to contact the parents within reasonable time. Therefore, parents are asked to authorise the teacher in charge to give permission to the Doctor in charge to undertake to act in their absence, and to give consent to whatever treatment may be necessary. It is understood that he/she will only act in a case of emergency. If you agree to this please sign below.

I _____ (name of Parent/Guardian) hereby authorise the teachers in charge (Miss Boon/Mr Pratt/ Mrs Afzal/ Mrs Green) to give permission to the Doctor in charge to undertake whatever emergency treatment is considered necessary for my son/daughter.

Any relevant medical information (e.g. allergies to drugs etc.)_____

Date of last tetanus injection (if known) _____

Daytime emergency contact telephone number: _____

Evening telephone number: _____

Doctor's Name, Telephone No. and address

_____

_____

Signed: _____

Date: _____

DIETARY REQUIREMENTS
If there are any special dietary requirements (e.g. vegetarian, allergies to foods or colouring) please state below:-

Please return by Friday 7th February 2014