

ADDITIONAL INFORMATION FOR BATTLEFIELDS EXPERIENCE

Student Name

Please detail any specific dietary requirements (allergies, vegetarian etc.)

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In an emergency please contact the following person if you cannot contact parents/carers;

Surname **First Name**

Relationship to Student

Address

.....

Tel No (Day) **Tel No (Evening)**

The first aider on each bus will carry some generic medication as detailed below. If you are **happy** for your child to have any or all of these medicines please tick as appropriate;

- Paracetamol**
- Antihistamine**
- Travel sickness/sea sickness**

If your son/daughter requires their own prescription or non-prescription medication during the trip this should be handed to and administered by the Bus First Aider. Please complete the School Administer Medication Form overleaf for any such medication and hand the medication into school by Wednesday 08/05/19. If you would prefer that your child carries their own medication please arrange to fill out the Medication to Be Self-Administered Form. Students should not be carrying any medication not detailed on these forms and be aware that the medication is for their use only.

Please read the following statements and tick those you **agree** with;

- I give permission for my child to receive emergency dental, medical or surgical treatment, including anaesthetic, as considered necessary by the medical authorities present
- I give permission for suntan lotion to be given to my child to apply themselves

I confirm that I will inform the school of any changes in medical circumstances between now and the start date of the trip

Signed **(Parent/Carer)** **Date**.....

Please print Signatory's name.....

Form 4: Request for school to issue long-term 'as required' prescribed medication in school

To be completed by parent/carer





Pupil's name	Date of birth
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I request that the above pupil be given the following medication while at school. I have given the first dose of this medication to my child and no adverse reaction has been observed.

Name of medication	Dose prescribed	Minimum time between doses	Medication to be given if the following symptoms occur

The GP or hospital doctor has prescribed the above medication. It is in the container in which it was dispensed, clearly labeled with the contents, dosage and child's name in full.

I realise that this is not a service that the school is obliged to undertake. I accept full responsibility for informing the school if my child has been given a dose of this medication before coming to school. I accept responsibility for ensuring that the medicine has not expired and that there will be enough medicine supplied to the school for my child's needs. I will collect all unused medicine from the school at the end of the summer term. I accept that the school will destroy any unused medication that remains uncollected.

Parent/carer's name (please print)	
Address	 Home
	 Work
	 Mobile
@	
Name of G.P.	
Address of G.P.	 G.P.
Signature of Parent/Carer	Date

Note: The school will not accept medication unless this form is completed and signed by the parent/carer of the pupil and the head teacher agrees the administration of the medication. The head teacher reserves the right to withdraw this service.