NETHER STOWE SCHOOL
MEDICAL FORM – RESIDENTIAL VISIT

Year 7 visit – Whitemoor lakes 28th – 29th September 2021

Name of child…….. Date of Birth ……

Address ……

…… Home Telephone No. ……

Name of parent or contact(s)…..……Relationship ……..

Work Telephone No. …….. Mobile Telephone No. ……

Other numbers.....

(Please provide all possible numbers to contact you during the day
If your child needs to be collected as a matter of urgency, we must be able to contact you without delay) This includes if they suddenly present with any symptoms of covid 19.

IF THE ANSWER TO ANY OF THESE QUESTIONS IS 'YES' PLEASE GIVE FULL DETAILS OVERLEAF

(Please **circle** the appropriate answer)

1. Will your child need to bring any medications for treatment during the visit? YES NO

2. Has the participant suffered from, or been in contact with anyone suffering from, an infectious or contagious disease in the last four week YES NO

3. Does the participant suffer from?
   - a) Epilepsy YES NO
   - b) Diabetes YES NO
   - c) Asthma YES NO
   - e) Allergies (including to any medication) YES NO

I hereby give permission for my child to receive, if necessary, the following proprietary medications, at a dose appropriate to their age, to alleviate these complaints:

1. For colds causing congestion: Decongestant Lozenge (e.g. Tunes)
2. For headache: Paracetamol or Calpol
3. For insect bites or stings: Proprietary spray or cream

THIS SECTION TO BE COMPLETED ONLY IF THE ANSWER TO ANY QUESTION OVERLEAF IS 'YES'

1. Give details of any medical treatment needed during the day or medications that need to accompany the participant (**e.g. Hayfever remedies**).

2. Nature of infectious disease and how contracted during the past four weeks:

3. If your child suffers from **(a) EPILEPSY, (b) DIABETES, (c) ASTHMA**, please give FULL details below. These should include severity and frequency of attack, approximate date of the last attack and details of any medication taken regularly or kept for emergencies:

   Details of **(d) ALLERGIES**, including reaction to painkillers, antibiotics, analgesic and other propriety medicines and reactions to types of food i.e. nuts.

I declare that I have answered all the above questions to be best of my ability and have not knowingly withheld any information regarding physical fitness. I undertake to inform the leader in charge of any changes to the above between the date signed and the start of the visit.

…….. Date …….

Sign and Print Name (Parent/Parental Responsibility Holder)

This medical form must be returned to **MRS PHILLIPS** and will be taken on the visit.