



Sibford School

Health Information

Event:.....

Name of Pupil.....

Date of Birth:.....

Home address:

In an emergency

Contact telephone number.....

Mobile contact number.....

Family doctor

Name.....

Address

Telephone number.....

Date of last tetanus injection.....

General health information

Do they suffer from asthma, chest complaint, wheezing or hay fever, migraine, fits or faints, diabetes or any other illnesses or disability? YES/NO

Are they allergic to anything? (Antibiotics, particular foods or medication, etc) YES/NO

Are they receiving any medication treatment at present? YES/NO

Do they administer their own medication? YES/NO

If YES has been answered to any of the above questions please give details overleaf

The following medications will be available if required. Please indicate which maybe used by your child.

(To be added by trip co-ordinator)

.....YES/NO
.....YES/NO
.....YES/NO
.....YES/NO
.....YES/NO

Emergency permission

I authorise.....(Teacher in Charge)

To give permission for my child to receive medication as instructed above and any
Emergency dental, medical, surgical treatment, including anaesthetic, as considered
Necessary by the medical authorities present.

Signed.....Parent/guardian.....Date

Further information