Twiss Green Primary School

Educational Visit Emergency Contacts / Medical Information

Y6 Residential Visit: Colomendy Adventure Centre Date: 15th-16th September 2022

Child's Full Name: ……

Chosen Name (*if different)*: …… Date of Birth: …… Male / Female*

Home Address: …….

Post Code: …… Home Tel: ……..

Emergency Contacts: Please give FULL details of people to be contacted in the event of an emergency concerning your child, in the order you wish them to be contacted. **We MUST have names and addresses of ALL those with PARENTAL RESPONSIBILITY.**

1. Full Name of Contact: ……

Relationship to Child: ..... Parental Responsibility: **YES / NO ***

Daytime Tel No. ..... Place of Work: ……

Evening Tel No. …… Mobile No. ……..

Address (*if different from above)*:
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2. Full Name of Contact: ……

Relationship to Child: ..... Parental Responsibility: **YES / NO ***

Daytime Tel No. ..... Place of Work: ……

Evening Tel No. …… Mobile No. ……..

Address (*if different from above)*: .....

3. Full Name of Contact: ……

Relationship to Child: ..... Parental Responsibility: **YES / NO ***

Daytime Tel No. ..... Place of Work: ……

Evening Tel No. …… Mobile No. ……..

Address: .....

Medical Information

Please complete the medical questionnaire for your son/daughter*

Child's Name: …… D.O.B: …….

1. Has your child been immunised against tetanus in the last five years? Yes/No
(please give date if known)

2. Is your child sensitive to penicillin? Yes/No

3. Does your child suffer from fainting attacks or blackouts? Yes/No

4. Does your child suffer from fits or epilepsy? Yes/No

5. Does your child suffer from any allergy, asthma or hay fever? Yes/No

6. Does your child take any medication for the condition? Yes/No

7. Does your child suffer from diabetes? Yes/No

8. Does your child suffer from ear trouble? Yes/No

9. Does your child suffer from any illness, and/or injury not mentioned above? Yes/No
If yes, please give details including any infectious/contagious illness in the last three months and details of other recent illness/injuries or physical disabilities

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10. Are your child's teeth in good condition? Yes/No
If you are not sure, please get your dentist to check your child's teeth on a regular basis.

11. Is your child on any sort of medical treatment at the present time? Yes/No
Is the treatment self-administered? Yes/No
If yes, please give details:

Name of medicine: ……

How often taken? ……

12. Please indicate any special dietary requirements due to medical, religious or moral reasons: Yes/No

13. Does your child suffer from travel sickness? Yes/No

14. Does your child suffer from incontinence problems? Yes/No

15. Can your child swim? Yes/No How far?

16. Are there any activities in which your child may not participate? Please give reasons:
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17. Is there any other information which school should be aware of, e.g. suffers from vertigo, Claustrophobia or is frightened of the dark, etc?

Signed Parent/Guardian…….. Date……..