MEDICAL CONSENT FORM

For students under 18 years of age, a parent or guardian must complete this form.

For students over 18 years of age, please complete this form yourself.

FAMILY NAME _____

FIRST NAME _____

DATE OF BIRTH (DD/MM/YYYY) _____

GENDER Male ☐ Female ☐ Blood Group _____

HOME ADDRESS _____

_____

EMERGENCY CONTACT DETAILS: Name _____

Telephone_____ Relationship to student _____

MEDICAL INFORMATION

Did the student ever have:	**Please tick:**		
MEASLES	YES ☐	NO ☐	Date_____
CHICKEN POX	YES ☐	NO ☐	Date_____
RUBELLA	YES ☐	NO ☐	Date_____
MUMPS	YES ☐	NO ☐	Date_____
MENINGITIS	YES ☐	NO ☐	Date_____
HEPATITIS	YES ☐	NO ☐	Date_____

If YES please specify _____

Does the student suffer from and or take medication for:			
DIABETES	YES ☐	NO ☐	Date_____
EPILEPSY	YES ☐	NO ☐	Date_____
ASTHMA	YES ☐	NO ☐	Date_____
CARDIAC DISEASE	YES ☐	NO ☐	Date_____
ECZEMA	YES ☐	NO ☐	Date_____
MIGRAINE	YES ☐	NO ☐	Date_____
FAINTING	YES ☐	NO ☐	Date_____
OTHER	YES ☐	NO ☐	Date_____

If YES please specify _____

Did the student have any recent fractures / broken bones / injuries in the last year that have ongoing consequences ?

YES ☐ NO ☐

If YES please specify _____

Has the student suffered from any illnesses or diseases in the last year that have ongoing consequences ?

YES ☐ NO ☐

If YES please specify _____

Does the student suffer from

Allergies / Intolerances / Sensitivities? YES ☐ NO ☐

If YES please specify _____

Does the student take any medication on a regular basis?

YES ☐ NO ☐

If YES, please specify _____

Please ensure you bring sufficient medication in its original packaging with you for your stay at Harrow House

Does the student suffer from any other condition that is important for us to know?

YES ☐ NO ☐

If YES, please specify _____

CONSENT TO TREATMENT

I give permission for the student to receive the following non prescribed medication from the College Matron:

Paracetamol	YES ☐	NO ☐	Diarrhoea remedy	YES ☐	NO ☐
Ibuprofen	YES ☐	NO ☐	Dehydration treatment	YES ☐	NO ☐
Antihistamine	YES ☐	NO ☐	Head lice treatment	YES ☐	NO ☐
Cough syrup	YES ☐	NO ☐	Sticking plasters	YES ☐	NO ☐
Antacid	YES ☐	NO ☐	Antiseptic wound cleanser	YES ☐	NO ☐
Constipation remedy	YES ☐	NO ☐	Natural oils	YES ☐	NO ☐
Antiseptic throat spray/lozenges	YES ☐	NO ☐			

I give permission for the student to receive the following medical treatment where necessary:

First aid	YES ☐	NO ☐	Optician	YES ☐	NO ☐
GP appointment	YES ☐	NO ☐	Emergency hospital treatment	YES ☐	NO ☐
GP prescribed medication	YES ☐	NO ☐	Blood transfusion	YES ☐	NO ☐
Dentist	YES ☐	NO ☐	General anaesthetic	YES ☐	NO ☐

In the event of a medical emergency, you will be contacted at the earliest possible time to give updates and seek detailed consent.

A child (anyone under the age of 16 years) can consent to treatment as long as they have enough understanding and intelligence to appreciate fully what is involved in their treatment. This is known as being 'Gillick competent'. Additional consent by a person with parental responsibility is not required. Any person over the age of 16 years is deemed capable of consenting to their own treatment.

I confirm that the student has sufficient supplies of prescribed medication for the entire length of their stay.

I confirm that the information given is true to the best of my knowledge and understand that any information given will be held in confidence.

SIGNATURE _____ **DATE**_____

RELATIONSHIP TO STUDENT (Father / Mother / Guardian) _____