

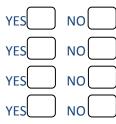
MEDICAL CONSENT FORM

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		ale	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		Date				
MUMPS	YES		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		Date				
EPILEPSY	YES		Date				
ASTHMA	YES		Date				
CARDIAC DISEASE	YES		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 illnes	sses or diseases in the	last year that have ongoing conseq	uences ?			
	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 o	n 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					
If YES, please specify						
CONSENT TO TREATMENT						
I give permission for the student to rece			llege 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		Antiseptic wound cleanser	YES NO			
Constipation remedy	YES NO	Natural oils	YES NO			
Antiseptic throat spray/lozenges						
I give permission for the student to receive the following medical treatment where necessary:						
is give permission for the student to rece						

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



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 ______ DATE ______

RELATIONSHIP TO STUDENT (Father / Mother / Guardian) _____