

MEDICAL INFORMATION AND CONSENT FORM 2011

To be completed by the parent/guardian/carer if student under 18 on the 31/08/2011



The following details are recorded on our system, please amend and/or add as necessary

Personal Details			
Name		Date of Birth	
Course Code		ID Number	

Emergency Contact Details

Please tick in box alongside name if person listed should **not** be contacted about the student's academic progress and attendance.

Parent/Guardian/Carer 1st contact Tick box if not to be contacted about academic progress and/or attendance

First Name		Relationship to Student	
Last Name		Evening Phone Number	
Address		Mobile Phone Number	
		Day Phone Number	
Post Code		Email Address	

Parent/Guardian/Carer 2nd contact Tick box if not to be contacted about academic progress and/or attendance

First Name		Relationship to Student	
Last Name		Evening Phone Number	
Address		Mobile Phone Number	
		Day Phone Number	
Post Code		Email Address	

If there are other people not listed above who should be contacted about the student's academic progress and attendance, please provide details on a separate sheet.

Additional Emergency Contact 1 Tick box if not to be contacted about academic progress and/or attendance

First Name		Last Name	
Relationship to Student		Day Phone Number	
Evening Phone Number		Mobile Phone Number	
Email Address			

Additional Emergency Contact 2 Tick box if not to be contacted about academic progress and/or attendance

First Name		Last Name	
Relationship to Student		Day Phone Number	
Evening Phone Number		Mobile Phone Number	
Email Address			

Please tick the appropriate box if you agree/do not agree to

	Yes	No
I agree to my son/daughter participating in approved learning activities as part of the course of study which may take place OFF the college premises within the United Kingdom for ONE day only (trips involving overnight stays will require separate permission from you)	<input type="checkbox"/>	<input type="checkbox"/>
I give permission for my son/daughter to attend Student Association social events.	<input type="checkbox"/>	<input type="checkbox"/>
I give permission for my son's/my daughter's school to be notified of his/her enrolment, examination results and destination after leaving college.	<input type="checkbox"/>	<input type="checkbox"/>
I give permission for images of my son/daughter to be used for newsletters, prospectuses and on the college website	<input type="checkbox"/>	<input type="checkbox"/>
I understand that the copyright and intellectual property of my son's/daughter's work which is originated solely by my son/daughter, remains with my son/daughter. I also understand that if my son/daughter receives assistance with his/her work from staff or other students then the copyright and intellectual property rights are shared.	<input type="checkbox"/>	<input type="checkbox"/>
I give permission for my son's/daughter's original work (such as paintings, comments or artefacts) to be published in college publications.	<input type="checkbox"/>	<input type="checkbox"/>
<i>For students who have work placement as part of their course</i> I give permission or my son/daughter to undertaken periods of unpaid work experience in various settings throughout the duration of his/her course. I will ensure that the Work Experience Co-ordinator or Personal Tutor is aware of any medical conditions that may need to be considered.	<input type="checkbox"/>	<input type="checkbox"/>

Data Protection Consent - must be completed by the student.

In order to share information in connection with your studies with your parent(s), guardian(s), carer(s), please indicate which of these persons you agree to allow us to contact.

Parent <input type="checkbox"/>	Guardian <input type="checkbox"/>	Carer <input type="checkbox"/>	Name	
Name of Student			Signature of Student	

Student Medical Information Please provide full medical details and ensure these are updated where necessary

Name of Doctor (GP)		Surgery Address	
Name of Surgery		Post Code	
Surgery Phone Number			

Does your son/daughter have any of the following?

Anaphylaxis Yes <input type="checkbox"/> No <input type="checkbox"/>	Severe allergy Yes <input type="checkbox"/> No <input type="checkbox"/>	Triggers	Emergency Medication & where carried?
Severe Asthma Yes <input type="checkbox"/> No <input type="checkbox"/>	Other ongoing breathing difficulties Yes <input type="checkbox"/> No <input type="checkbox"/>	Medication	Where carried?
Panic Attacks Yes <input type="checkbox"/> No <input type="checkbox"/>	Trigger		
Type 1 Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/>	Regular medication	Dosage/frequency	Emergency sugars / medication & where carried
Epilepsy Yes <input type="checkbox"/> No <input type="checkbox"/>	Other seizure Yes <input type="checkbox"/> No <input type="checkbox"/>	Type of seizure	Emergency instructions, including any emergency medication
Head Surgery Yes <input type="checkbox"/> No <input type="checkbox"/>	Serious Head Injury Yes <input type="checkbox"/> No <input type="checkbox"/>	Nature of surgery and/or injury	Ongoing effects
Other Recent Surgery Yes <input type="checkbox"/> No <input type="checkbox"/>	Recent Injury Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Surgery/Injury	Ongoing effects
Heart condition Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of condition	Effects	Emergency instructions
Other Chronic Health Condition(s) Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Condition	Medication	Effects
Has your son/daughter received a tetanus immunisation in the last five years? Yes <input type="checkbox"/> No <input type="checkbox"/>			Date of immunisation
Is your son/daughter receiving current medical treatment and has he/she been given specific advice to follow? Yes <input type="checkbox"/> No <input type="checkbox"/>			Details
Is there any special information that the first aider should be aware of? Yes <input type="checkbox"/> No <input type="checkbox"/>			Details
Is a medi-alert bracelet/necklace worn? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Does your son/daughter have a special diet Yes <input type="checkbox"/> No <input type="checkbox"/>			Vegan <input type="checkbox"/> Vegetarian <input type="checkbox"/> Coeliac <input type="checkbox"/> Other

Confirmation To be signed by the parent/guardian/carer

I agree that the medical information is accurate and up-to-date to the best of my knowledge. I will take responsibility for informing my son/daughter's Personal Tutor throughout the year of any changes to this information. Any changes of contact details will be communicated to the college/Team Administrator.

In the event of serious injury or illness, every attempt will be made to contact parents/guardians/carers immediately, but it is important that emergency treatment is not delayed while permission for treatment is being sought. For all students, it is useful to have prior permission for any such treatment (eg anaesthetics or blood transfusions), and for any treatment deemed necessary by qualified medical staff.

I give my permission for the emergency medical services to carry out essential procedures Yes No

Signature of Parent/Guardian or Carer:	Name (in capitals):
	Date: