

SAMPLE MEDICAL INFORMATION AND CONSENT FORM
CONFIDENTIAL

Please print details and sign below.

I/We _____

of (address) _____

consent to the accompanying staff members of the _____ Tour seeking medical or dental advice on behalf of my/our child as they see fit in the event of accident or illness. If, in the opinion of the attending medical or dental practitioner or medical officer, my/our child requires medical or dental attention or treatment including but not limited to the administration of anaesthetic, blood transfusion or the performance of any surgical operation, I/we consent to such medical or dental practitioner or medical officer giving such treatment.

I/we certify that the accompanying staff will take all reasonable care of my child, however, neither they nor the school will be responsible for the cost of any medical or dental attention or treatment administered to my child.

The accompanying staff will not be responsible for any act or omission of any medical or dental practitioner or medical officer attending or treating my child.

Parent/Guardian: _____
(Signature)

Student: _____
(Signature)

Date: _____

STUDENT DETAILS

Name: _____

Address: _____

Contact phone no. _____

Date of Birth: _____ Passport Number: _____

Travel Insurance: Company Name: _____

Policy Number: _____

1. Emergency Contacts

(i). Name _____

Relationship to Student: _____

Address: _____

Phone: (hm) _____ (wk) _____

Fax: (hm) _____ (wk) _____

Email: _____

(ii) Name _____

Relationship to Student: _____

Address: _____

Phone: (hm) _____ (wk) _____

Fax: (hm) _____ (wk) _____

Email: _____

2. Does your child have any special dietary requirements? YES NO

If yes, please give details:

3. Please indicate if your child suffers from any medical conditions that we should be aware of:

If your child requires medication for either 3 or 4, please provide the following information:

a) Name of medication: _____

b) Dosage: _____

c) Time(s) dosage to be taken: _____

Any other details:

4. Does your child have any allergies/intolerances to anything, including medications? YES

NO

If yes, please specify (include appropriate treatment)

5. Blood Type (if known): _____

6. Date of last injection for Hepatitis B: _____ TETANUS: _____

7. Is there any other relevant information we should be aware of?

PLEASE NOTE: Students are required to carry and administer their own medication. Back-up medication is advisable. Students must advise the accompanying staff when they self-administer any medication.