This information may be shared with third party providers. Should you wish to learn more how we process your personal and sensitive information, please refer to our Privacy Notice, which is located on our website. **Please complete all sections on both sides of this form in BLACK ink, and return to Mrs Pasqualino in the Quad Office.**

Student's Name:	**Tutor Group:**	**Date of Birth:**
Address		**Party Leader:**
Contact No. Home:		**Mobile:**

HAVE YOU EVER HAD:	**YES**	**NO**	**IF YES, DESCRIBE**
Heart trouble, raised blood pressure			
Asthma, Bronchitis, Tuberculosis			
Diabetes			
Epilepsy, Fainting Attacks, Migraine, Severe head injury			
Nervous illness			
Hayfever, Allergy e.g. to medicine, insect bites, food.			
History of fractures, or tendon/ligament damage e.g. back, neck, arms, ankles or knees.			
Are you suffering from, or a carrier of, any infectious disease?			
Have you been treated by a Doctor/or in hospital over the last two years?			
Have you any special dietary requirements? Allergies, Gluten, nuts, vegetarian Halal etc.			
*Are you taking any medication?			

***If your son/daughter will need to take medication whilst on the residential trip, please ALSO refer to, download and complete an 'Administration of Medication on School Visits' form, which can be found on the School's website in the 'Student & Parents Info' section under 'Useful Documents'.**
**** Epipen and Inhalers must be carried by the student at all times and a second set should be handed into Pupil Reception prior to the Residential Trip taking place, clearly labelled with name, instructions and the trip name, so that this can be passed to the Party Leader for the duration of the trip.**

Please give date of your last tetanus injection:

Any other relevant medical information:

Parent/Carer's email address:

Please give the name, address and telephone number of the Family Doctor:

Name: Telephone:

Address:

Please give address and telephone number of next of kin if not at home during time of trip.

Name: Telephone:

Address:

Authorisation for Examination, Treatment, Surgery

Autorisation D'Opérer & De Pratiquer des Soins et Examens

Genehmigung für nötige Behandlung, Untersuchung und chirurgische Operationen

I the undersigned /Je soussigné (e) / Ich _____

Relationship to the child / Lien de parenté / Verwandtschaft mit dem Kind _____

give permission to carry out any necessary examinations, treatment or operations on my child.

donne l'autorisation de pratiquer les examens nécessaires et d'opérer mon enfant.

gebe meine Genehmigung für alle nötige Untersuchungen oder Operationen.

Surname of Patient / Nom du malade /Name des Patienten _____

First Name of Patient / Prénom / Vorname _____

Signed: Parent/Carer Date/Le /Datum:

I declare that the above answers are true and that I have not withheld any information.

Signed: Parent/Carer Date: