Corfe Hills School

High Expectations | Exceptional Individuals

CONFIDENTIAL MEDICAL QUESTIONNAIRE TO BE COMPLETED FOR ALL OFF SITE ACTIVITIES

Please see the school's Privacy Notice found on the school website for information about how the data you provide is collected, stored and shared.

Name of Participant:	Participant Date of Birth:
	Participant Aged 18 or over: Yes / No
Name of Next of Kin:	Next of Kin Home Phone Number:
	Next of Kin Mobile Phone Number:
	Next of Kin Work Phone Number:
Next of Kin contact address (during the activity):	
Name of Participant's Doctor:	
Phone Number of Participant's Doctor:	
Address of Participant's Doctor:	
Participant's blood group (if known):	Participant's NHS Number:
For some activities it will be necessary to know participants' weight and height for safety reasons. Where this is the case it will be requested separately.	

Has the participant had any of the following?

Asthma or bronchitis	Yes	No
Heart Condition	Yes	No
Fits, fainting or blackouts	Yes	No
Severe headaches	Yes	No
Diabetes	Yes	No

Allergies to any know medication	Yes	No
Any other allergies, eg material food, plasters	Yes	No
Other illness or disability	Yes	No
Travel sickness	Yes	No
Regular medication	Yes	No

If the answer to **any of these questions is Yes**, please give details:

If it is considered necessary, do you agree to mild pain killers (eg Paracetamol) being administered?	Yes	No
If it is considered necessary, do you agree to blood transfusion?	Yes	No
Has the participant received vaccination against Tetanus in the last 10 years?	Yes	No
Is the participant receiving medical or surgical treatment of any kind from the family doctor or hospital?	Yes	No
Has the participant been given specific medical advice to follow in emergencies?	Yes	No

If the answer to **either of the last two questions is Yes**, please give details here (including dosage of any medicines/tablets).

Cont.

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CONFIDENTIAL MEDICAL QUESTIONNAIRE FOR ALL OFF SITE ACTIVITIES CONTINUED

Please see the school's Privacy Notice found on the school website for information about how the data you provide is collected, stored and shared.

If there is any other relevant information relating to your child's health or medical treatment, please specify this.
Brief medical history including dates of vaccinations and hospitalisation.

For the participants under 18 years of age In the event of it being necessary for the participant to be admitted to hospital (Please tick one or both boxes)

I confirm that I hold a current passport and will be prepared to collect the participant from hospital on release.	
If I am unable to collect the participant from hospital on discharge I give permission to ________________________ (name of teacher) to release the participant from hospital if necessary.	

In the event of any illness or medical treatment occurring after the return of this form and prior to the activity, I undertake to inform the party leader.

I appreciate that staff in charge of the visit will take all reasonable care and will act in loco parentis in the event of an emergency but cannot be responsible for the loss or damage to personal property.

For participants under 18 years

Name: Person with parental responsibility	
Signed:	Date:

For participants 18 years and over

Signed: Participant	Date: