Please complete this form in **CAPITAL** letters and return to the school as soon as possible.

1. **GENERAL INFORMATION Surname of Child**

**Home Address of Pupil**

**POSTCODE:**

**First Name(s) of Child**

**Emergency Telephone Numbers (this should be the parents or those with parental responsibility)**

Telephone number Name & Relation to Child

Daytime

Night

(These numbers must be contactable at all times while your child is away)

**Date of Birth**

**Name & Address of Child’s Doctor**

**POSTCODE:**

1. **DIETARY INFORMATION**

Does your child have any particular dietary requirements? **🗆 Yes 🗆 No**

If **Yes** please provide details and reasons below E.g. No nuts – severe allergic reaction

No onions – strong dislike

Reason

(If vegetarian, does he/she eat fish?)

(If vegetarian, does s/hgepwoiegpighngfh

Item of food

1. **MEDICAL INFORMATION**
2. Does your child suffer from an allergy? 🗆 Yes 🗆 No If  **Yes**, please give details below:-
3. **MEDICAL INFORMATION**

1. Does your child suffer from an allergy? 🗆 Yes 🗆 No If Yes, please give details below:-

1. Does your child suffer from any illness/health or behavioural problem? 🗆 Yes 🗆 No

If **yes,** please give details below:-

1. Is your child taking any medication or tablets? (including asthma treatment)? 🗆 Yes 🗆 No

This includes any medication that they take at home

If yes, we must have written details of this medication and the treatment obtained from your child’s doctor.

1. Is your child diabetic? 🗆 Yes 🗆 No

If yes, you must send written details of treatment, obtained from your child’s doctor.

4b. Is your child epileptic? 🗆 Yes 🗆 No

4c. If Yes to 4a or 4b does your doctor approve this visit? 🗆 Yes 🗆 No

1. What was the date of the last known tetanus injection?
2. What is your child’s NHI Medical Card Number?

NHI:

1. Please give any further relevant information (including bed wetting, special needs):
2. Have you signed a school Health Care Plan (HCP) for your child’s medical needs or prescribed medication?

🗆 Yes 🗆 No

Has your child ever flown before: Yes / No

Is your child scared of flying: Yes / No / Do not know

Please tick if when travelling does your child suffers from any of the following conditions

|  |  |
| --- | --- |
| **Condition** | **Yes** |
| Coach sickness |  |
| Air sickness |  |
| Pressure to ears on plane |  |
| Pressure to nose on plane |  |
| If you ticked yes to any of the above 4 conditions does your child take any medication for it? Yes / No | |
| If yes, what is the medication? You will also need this to be prescribed by a doctor and have a care plan in place? |  |

Please tick if you wish your child to use any of the following items:-

|  |  |
| --- | --- |
| **Item** | **Yes** |
| Deodorant |  |
| Body cream |  |

**THIS INFORMATION WILL BE TREATED AS CONFIDENTIAL**

1. **Declaration by parent or guardian/ carer (delete any section if required)**

**I consent to my child, named above, to receive any necessary emergency medical or dental treatment during her/his visit to Spain. I will inform the school of any new illness or injury affecting my child in the 2 weeks before the trip.**

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**