**HEATREE RESIDENTIAL VISIT**

**MONDAY 24th – FRIDAY 28TH 2019**

Name of Child .......................................................................................................................….

Name of GP...............................................................................................................................

Address of GP's

Surgery.......................................................................................…..........……..........................

...................................................................................................................................................

Surgery Tel. No...........................................................................................................….....................

Home Tel. No.......................................................................................................................................

Work Tel. No........................................................................................................................................

Emergency Tel. Nos. 1).....................................................................

 2)....................................................................

Is your child taking any medication? If yes, please give details:

(Please hand any medication, named, to Mr Hill or Mrs Jones on the Monday morning, 24th June, with full instructions. Children should be responsible for their own inhalers, if required)

Has your child had any recent illness? If yes, please give details:

Are you aware of any drug that your child may be allergic to?

Does your child have any specific dietary requirements?

Any other information you feel may be useful:

(i.e. sleepwalking, bedwetting, travel sickness, hay fever, asthma (see above re. inhalers). Please provide adequate supplies of travel pills or anti-histamine tablets/eye drops/inhalers. Travel pills to be taken, if necessary, before coming to school on Monday 24th June.

Please tick the medicines you are happy for us to administer to your child if necessary:

Calpol Sting Relief After sun Throat pastilles

I consent/do not consent to any emergency medical treatment required by my child during the course of the visit. (Please delete as applicable)

Signed ............................................................ Parent/Guardian