Baverstock Oaks School
Chosen Valley Camp 2018

Please return as soon as possible

Baverstock Oaks School

Student Information

Name: **Year: 5**

Address:

Parent name/s:

Parent email: **Parent mobile:**

1 Please tick if your child has any of the following:

- □ Migraine
- □ Epilepsy
- □ Asthma
- □ Diabetes
- □ Travel Sickness
- □ Fits of any type
- □ Chronic nose bleeds
- □ Heart Condition
- □ Dizzy Spells
- □ Colour Blindness
- □ Other – Please specify

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2 Medical Alert Number (if applicable)

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3 Date of last tetanus injection? (if known)

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4 Is your child currently taking medication?

- □ No
- □ Yes – Please state ailment/s

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……..……

Name of medication/s

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Dosage & time/s to be taken

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……..……

Other treatment

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5 Has your child had any major injuries (breaks or strains) or illness (glandular fever etc.) in the last six months that may limit full participation in any activities?

- □ No
- □ Yes – Please specify

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6 Is your child allergic to any of the following?

Prescription medication

- □ No
- □ Yes – Please specify

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Food

- □ No
- □ Yes – Please specify

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Insect bites/stings

- □ No
- □ Yes – Please specify

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Other allergies

- □ No
- □ Yes – Please specify

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Treatment required?

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7 What pain/flu medication may your child be given if necessary?

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8 Please tick if your child does the following:

- □ Bedwetting
- □ Sleepwalking

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9 Is there any other information that staff should know to ensure the physical and emotional safety of your child? Eg. Cultural practices, disability, anxiety about heights/darkness/small places, behavioural or emotional problems)

- □ No
- □ Yes – please give brief details

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10 Are there any foods your child is unable to eat due to cultural or religious beliefs?

- □ No
- □ Yes – please give brief details

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11 Is there any additional information we should know about your child's eating habits?

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Please advise if your child comes into contact with any contagious or infectious diseases before Chosen Valley Camp (in the four weeks prior).

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