**MEDICAL FORM AND REQUEST FOR BERKEKELY GUARDIANS TO ADMINISTER MEDICATION**

Berkeley Guardians will not authorise for your child to be administered medicine unless you complete and sign this form, and the Directors have agreed that Berkeley Guardians staff/homestay providers can administer the medication.

**DETAILS OF CHILD**

Forename(s)..................................... Surname ...................................................

Address...........................................................................................................................................................

M/F ............................................. Date of Birth...................................................

Boarding School Name/Address

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Nationality…………………………………………………..

English Level…………………………………..

Blood Group……………………..…

Height……………….……………Weight…………………………….

Any Condition or Illness Click or tap here to enter text..........................................................................................................................................................................................................................................................................................................................................

Is your child fit to take part in sporting activities or physical exercise

Yes[ ]  No……….

**Vaccinations**

Vaccinations….…………………………………..Date……………………………..

Vaccinations……………………………………..Date………………………………

Vaccinations….…………………………………..Date………………….………….

Vaccinations……………………………………..Date……………………………..

Vaccinations……………………………………..Date………………………………

**Hospital**

Has your child ever been hospitalised

Yes [ ]

No [ ]

Please give details

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**Does your child suffer from any on the following?**

Diabetes [ ]   Asthma [ ]

Allergies (including latex) [ ]  Bronchitis  [ ]

Heart condition [ ]  Hearing problem [ ]

Sight problem  [ ]  Fits or convulsions  [ ]

Migraine  [ ]  Hay fever [ ]

Skin conditions [ ]  Orthopaedic/speech [ ]

Contact lenses/glasses [ ]

Any other condition

……………………………………………………………………………………………………………..

If yes to any of the above, please provide full details

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Doctor Details**

Name

………………………………………………………………………………………………………………………….

Address

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Contact: Tel (and area code)

…………………..……………..………………………………………………………………………………………..

Email……………………..………………………………………………………………………………………….

**MEDICATION**

Name/Type of Medication (as described on the container)

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Date dispensed ...............................................................................................................................

Is this medicine prescribed from a Medical Practioner [ ]  or Homeopathic [ ]

**Full Directions for use:**

Dosage....................................................................................................................................................

Self-Administration (please tick box) Yes [ ]  No [ ]

Frequency (please delete as appropriate)

As required Daily (please state how many times per day) ...............................................................................

Special Precautions/Instructions: ………………………………………………………………………..

Possible side effects............................................................................................

Procedures to take in an Emergency:

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**Minor illness/injury**

There may be times your child will need first aid, paracetamol or other pain relief medication. Please indicate if you authorise a member of Berkeley Guardians to provide such medication to your child if upon their judgment your child would benefit from such medication.

Please tick Yes [ ]  No [ ]

**Hospital/Dental Treatment**

In a medical emergency, should you not be able to be contacted, you give consent for any procedure considered necessary by a qualified doctor or dentist to take place in order to ensure the health and safety of your child.

Please tick Yes [ ]  No [ ]

**CONTACT DETAILS**

Name(s) ....................................................................................................................................................................................................................................................................................................................

Relationship(s) to child ...............................................................................................................................

Address ..........................................................................................................................................................................................................................................................................................................................................

Daytime Telephone No(s) ..................................................... /.............................................................

I understand that I must deliver the medicine personally (to agreed member of staff) and accept that this is a service which Berkeley Guardians is not obliged to undertake. [ ]

Signed (Parent/Carer) 

Dated .................................................................................................................

Signed(Parent/Carer) 

Dated .......................................................................................