

Child's Name..... Class.....

Date of birth

SECTION C

Please circle as applicable

- 1. Does your child suffer from any allergies? YES NO
- 2. Is your child taking any medication at present? YES NO
- 3. Does your child suffer from any condition that may affect participation? YES NO
- 4. Has your child been in contact with any contagious or infectious disease or suffered from anything in the past four weeks that may become Infectious or contagious? YES NO
- 5. When did your last have a tetanus injection? Date.....
- 6. Does your child have any special dietary requirements? YES NO
- 7. Is there any activity in which your child must not participate? YES NO

IF YOU HAVE ANSWERED YES TO ANY OF THE QUESTIONS ABOVE PLEASE GIVE DETAILS HERE:

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SECTION D PARENTAL/CARER AGREEMENT TO RECEIVING EMERGENCY MEDICAL TREATMENT

Pupil Date of Birth.....

Name, telephone number and address of Family Doctor

*I agree to my child receiving emergency medical treatment, including blood transfusion, and anaesthetic as considered necessary by the medical authorities present.

*I agree to my child receiving medical treatment/anaesthetic as considered necessary by the medical authorities present with the exception of the administration of blood or blood products. I accept full legal responsibility for this decision and release West Lothian Council and its staff from any liability for any consequences resulting from my decision not to consent to the transfusion of blood or blood products.

(*please delete as appropriate)

Date..... Signed by Parent/Carer