Wild Bee Forest School

Medical Information (Child)

Child(ren)'s Name

Date of Birth

Sex M F

Parent's/Guardian's Name

Mobile Phone

Next of Kin

Address

Emergency Contacts

Primary Emergency Contact

Secondary Emergency Contact

Mobile Phone

Second contact number

Mobile Phone

Second contact number

Medical Information

Allergies/Special Health Considerations, e.g. asthma, sight/hearing difficulties, heart condition, diabetes, epilepsy, allergies (pollen, nuts, medicines, etc.), adverse reactions to bee or wasp stings

Dietary requirements

I give consent for my child to be given:

- [ ] Antihistamine cream for bites and stings
- [ ] Sunscreen
- [ ] Any prescription medicine that you provide (including inhalers etc.)

I hereby grant permission for emergency medical treatment or medication to be administered to the above named child(ren) by on-site first aiders or qualified medical respondents in the event of an accident:

Parent's/Guardian's Signature

Date