St. Olave's Grammar School
Outdoor Expeditions Medical Form

1. Student's details

Student's full name: _____

Form:_____ DOB:_____

2. Student's health service details

Does the participant have:	Yes	No
• A heart condition, blood circulation condition, or problems with breathing, including asthma?		
• A bone or joint condition, weak muscles or tendons, including Osgood-Schlatters disease?		
• anxiety, stress, seizures, autism, or psychological disorders?		
• Received or waiting for any hospital or treatment for any condition?		
• Been referred to or seen by a hospital doctor or surgeon during the past 12 months?		
• To currently taking any prescribed medication?		
• To carry/use an epi-pen?		
• An allergy or any anxieties relating to dogs?		

Please tick if the participant has any of these allergies

Hayfever		Penicillin		Nuts		Other - please specify	

If you have answered yes to any of the above please specify below

Name of family doctor: _____ Tel: _____

Address: _____

3. Emergency contact details

Contact telephone numbers of **parents / carers.**

First Contact Name:_____

Work: _____ Mobile: _____

Home address and telephone:

_____

_____

Second Contact name:_____

Work: _____ Mobile: _____

Home address and telephone (if different from above):

_____

_____

Alternative emergency contact:

Name: _____ Tel number: _____

Address: _____

_____

4. Parental/Carer Consent

I consent to my child taking part in the

If a situation arises where a student has a serious accident every effort will be made to contact the parent/guardian. In the event of an emergency, any decisions on treatment will be taken by the medical professionals.

I agree to my child receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

I will inform the Trip Leader as soon as possible of any changes in medical or other circumstances between now and the commencement of the trip.

Signed: …… Date: ……..

Full name: ……

St. Olave's Grammar School
Medical Questionnaire (COVID-19)
Confidential upon completion

STUDENT'S NAME: ……

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING EITHER YES OR NO. ALL RESPONSES SHOULD TAKE INTO ACCOUNT YOUR HEALTH OVER THE LAST 14 DAYS			
A	Do you have/have you had a high temperature – this means you feel hot to touch on your chest or back (you do not need to measure your temperature)?	**YES**	**NO**
B	Do you have/have you had a new, continuous cough – this means coughing a lot more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)?	**YES**	**NO**
C	Do you have/have you had a loss or change to your sense of a smell or taste – this means you've noticed you cannot smell or taste anything, or things smell or taste different to normal?	**YES**	**NO**
D	Have any members of your household displayed symptoms of Coronavirus (COVID-19) within the last 14 days?	**YES**	**NO**
E	Is your household currently self-isolating or has been self-isolating within the last 14 days?	**YES**	**NO**
F	To the best of your knowledge have you been in close contact with anyone else who is symptomatic of COVID-19 within the last 14 days?	**YES**	**NO**
Please now answer the following questions circling either YES or NO:			
G	Do you accept that your participation in this activity may increase your risk of exposure to infection with the virus relative to no-participation?	**YES**	**NO**
H	Do you agree to inform the school should you develop any symptoms consistent with Coronavirus (COVID-19) any time within 14 days of the end of the course/activity?	**YES**	**NO**
I	In addition to the kit list provided, please confirm that you will bring: • A small bottle of hand sanitiser; • A face mask or covering with you in case it is required; • Protective gloves should you feel the need.	**YES**	**NO**
Please be aware that we may need to cancel your activity at short notice for COVID-19 reasons			

Parental Signature …… Dated ……