



# Creative Confidence Camp

## Medical Declaration Form

Get With The Kids Vibe

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
*One form per child*

Please provide details of individuals who are permitted to collect your child including their relationship. You will be required to inform us of any amendments to these details.

Name	Contact number	Relationship

**if different to the above, who should we contact in the unlikely event of an emergency?**

Name	Contact number	Relationship

**Does your child suffer from any allergies or food intolerances?** If yes, please outline under what circumstances the allergy may form and how it can be detected, i.e. if ingested / comes in contact with. Please enter 'none' if the answer is 'no'

**In the event of an allergic reaction, what authority and instructions are you providing our staff?** i.e. directions / use of Epi-Pen

**Does your child suffer from any other medical conditions? for example:**

Asthma, Panic Attacks, Epilepsy, Diabetes, incontinence, nose bleeds, fainting etc.? If 'no' please stipulate 'none'

**In the event of any of the above, what authority and instructions are you providing our staff or information that may prove useful to medical personnel?** For example, use of inhaler, dosage, any other medication etc.

**Is your child required to take any other form of medication whilst in our care or on any kind of medication at present?**

Please provide full details here and stipulate 'none' if the answer is 'no'

**Does your child have any dietary requirements or not permitted to eat certain things due to intolerance or religion?**

Please stipulate 'none' if the answer is no

**Are you aware of any special needs your child may have or conditions our staff should be aware of?**

For example, Hyper Mobility, ADHD, Autism, Learning difficulties, Sensitive to sound or light. Please stipulate 'none' if the answer is no

Name of General Practitioner:	
Name of Surgery / Address:	
Surgery Contact Details:	
NHS Number if known:	

In the event of emergency, I, the Parent/Guardian/Carer give full permission for the above child to receive medical attention by a qualified practitioner. I declare that any exceptions for example the rejection of blood transfusions are noted here.

Signed by (Name): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff member receiving this form: \_\_\_\_\_ Please submit this form to: [camp@getwiththekidsvibe.co.uk](mailto:camp@getwiththekidsvibe.co.uk)