

Unit 5 Axis Business
Centre
Westmead Industrial
Estate
Swindon
SN5 7YS



Tel: 0800 4332963
@bxmexpeditions
info@bxmexpeditions.co.uk
Company No.09584842



BXM EXPEDITIONS LIMITED
MEDICAL CONSENT FORM

Data Protection Act. *The information being collected on this form will only be used for the purpose of BXM Expeditions administration for the trip associated to this form and will not be used for any other purposes. The data will not be disclosed to any external sources other than in an emergency, or to the Local Education Authority, without your written consent.*

How is this data used? The personal data on this form is used by BXM Expeditions Limited only. We collect this data to ensure that all participants can be kept safe during their DofE Expeditions. Medical information disclosed on this form is given to BXM Expeditions Staff to ensure the safety of participants and where necessary used to contact parents/guardians/emergency contacts during the expedition or before the expedition event in order to find out more information surrounding a medical condition to ensure the safety of an individual.

These forms and their content are stored in locked cabinets or secure electronic files if received electronically and only BXM Expeditions Staff have access to these. Data is held for a period of one year, after this period all data is securely destroyed.

Please tick here if you want to opt out to receiving BXM Expedition marketing or promotional offers

1. Expedition event:.....
2. Name of participant:eDofE number.....
3. Age:..... Date of Birth:.....
4. Address:.....
.....
5. Emergency contact number(s):
Tel No Relationship to Child:.....
Tel No Relationship to Child:.....
6. Email Address:
.....
.....

7. Alternative Address & Tel No:

.....
.....
.....
.....

8. Personal Information: *Please give details requested below or personal information which might be relevant.*

(a) Has your child, to your knowledge, been in contact with any infectious illness in the last year?

YES / NO (*please circle*) If yes, give details:

.....
.....
.....

(b) Does your child suffer from allergies, Diabetes, Migraine, Epilepsy, bad period pains or any other illness or disability?

YES / NO (*please circle*) If yes, give details:.....

.....
.....

(c) Is he/she allergic to anything (e.g. antibiotics, Elastoplasts, Aspirin or any such medicines, any particular food etc)?

YES / NO (*please circle*) If yes, give details:.....

.....
.....

(d) Is he/she actively sensitive to penicillin?

YES / NO (*please circle*) If yes give details:.....

.....
.....

(e) Is he/she receiving any medical treatment at present?

(Asthma and Hay fever treatment are the responsibility of the student and do not need to be included here)

YES / NO (*please circle*) If yes, give details of illness/disability and treatment:

.....
.....
.....
.....

(f) Date of last anti-tetanus injection:.....
.....

(g) Does he/she have any special dietary needs (including any relating to religious beliefs?)
YES / NO (*please circle*) If yes give details.....
.....
.....

(h) Name & Address of own Doctor:.....
.....
.....
.....

9. **Insurance:** Participants are covered by BXM Expeditions in the event of negligence by one of its employees or agents. Please be aware that personal belongings or personal injury through inappropriate behaviour is not covered.

10. **PARENTAL CONSENT:**

- (i) I agree to my son/daughter taking part in the above activities.
- (ii) I understand that the staff responsible for the expedition will take all reasonable care of participants.
- (iii) I consent to any emergency treatment necessary. I therefore authorise BXM Expeditions staff to sign, on my behalf, any written form of consent required by the hospital authorities should medical treatment (a surgical operation or injection) be deemed necessary. Provided that the delay required to obtain my signature might be considered, in the opinion of the doctor or surgeon concerned, likely to endanger my child's health or safety.

Signature:.....
(*Please print your name alongside your signature*)

11. I give permission for photographs of my son/daughter to be used for school purposes
YES / NO (*please circle*)

Please complete as required following from point 8. (e)

Student name..... Date/...../.....

Medication 1 Reason for medication:.....

Name of medication:

Route of medication:

Side effects of medication:

Dose:

Frequency/time:

Storage instructions:

Medication 2 Reason for medication:.....

Name of medication:

Route of medication:

Side effects of medication:

Dose:

Frequency/time:

Storage instructions:

I the parent/carer understand that I must deliver the above medication to the instructor on the day of arrival and accept that this is a service which BXM Expeditions is not obliged to undertake.

I the parent/carer understand that I need to be available for a member staff at BXM Expeditions to be able to contact me in case of any emergency or for support/advice in relation to my child's medication and its management.

Signature:

Date:

Relationship to child: