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**ANAPHYLACTIC REACTIONS CONSENT FORM**

For the administration of medicine/treatment as discussed with the child’s parent or guardian.

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| **Childs Name**…………………………………………………………………………………………………..**Date of Birth** …………………………………………………..  Has the child’s details changed since the original Super Camps booking?  **Yes**  **No**  (E.g. new address, new doctor new contact details)  **New Details ;**  ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |
| **Information about the child’s allergy and reactions.**  The child has been identified as having a severe reaction to ;  ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  Signs and symptoms of the above child’s reactions are;  ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………............................................................................................ |
| **About the Medication that may be required or administered.**  Name/Type of Medication ………………………...……………………………………………………………………………………………………………..  Dose/Amount …………………....…………………….……………………………………………………………………………………………  Frequency /Times ………………….. .….…….…………………………………………………………………………………………………………  Specific Instructions ; ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  In the case of a reaction, Super Camps staff will follow the instructions as provided by the parent/guardian in treating the child.  In the case of a severe reaction Super Camps staff will adhere to the to the accident procedure found in the Policies and Procedures Document  I the Parent/ Guardian have provided the Super Camps staff with all of the necessary information required by them to deal with my child’s condition, the symptoms and the actions required in the event of my child suffering an allergic reaction.  It is my responsibility to provide and maintain the appropriate and up to date medication/treatment for my child.  I confirm that the above information is correct and give permission for Super Camps staff to administer the medication in the manner stated above.  **Signed Parent/ Guardian……………………………………………………………………………………………………………………………………………………….**  **Print Name…………………………………………………………………………………………Date …………………………………………………………………………** |
| **To be completed by Super Camps Staff if treatment is administered.**  Treatment Administered by ; ………………………………………………………... Signed………………………………………….……………………………………  Time ………………………………………………..……… Date…………………………………….. Head Office Notified Yes No  Signed Parent/ Guardian ……………………………………………………………………………………Name…………………………………………………………… |

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**ADMINISTRATION OF MEDICINE CONSENT FORM**

For the administration of medicine/treatment as discussed with the child’s parent or guardian.

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| **Childs Name**…………………………………………………………………………**Date of Birth** …………………………………………………..  Has the child’s details changed since the original Super Camps booking?  **Yes**  **No**  (E.g. new address, new doctor new contact details)  **New Details ;**  ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………. | | | | |
| **About the Medication**  Type of Medication ...…………………………………………………………………………………………………………………  Dose/Amount ..…………………….……………………………………………………………………………………………  Frequency .….…….……………………………………………………………………………………………………….  Administration Details ……………………………………………………………………………………………………………………  Reason for the Medicine. ………………………………………………………………………………………………………………….  I confirm that the above information is correct and give permission for Super Camps staff to administer the medication in the manner stated above.  **Signed Parent/ Guardian**………………………………………………………………………………………………………………………………  **Print Name** …………………………………………………………………………………………………**Date**………………………………………… | | | | |
| **Administration of medication record**  (Medication to be administer by camp manager and witnessed by a second member of staff) | | | | |
| Date | Time | Administered by  (print and sign) | Witnessed by  (print and sign) | Parent/ Guardian  (Print and sign) |
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