**Hospital Treatment Permissions Form**

Name of Child: ……………………………………………………………………………………………………. Date of Birth: ………………………….………….………..

If your child should require hospital treatment, we require the following information:

We will always try to contact parents and families prior to any hospital treatment.

Home Address: …………………………………………………………………………………………………………………………………………….……………………………….

………………………………………………………………………………………………………………………………………………………………………………………………………

**Parent/Carer**

Name: …………………………………………………………………………………………………………………………………………………………………………………………

Telephone No: ………………………………………….……………………………….. Work/Mobile No: …………………………………………………………………..

**Doctor**

Name: ……………………………………………………………………………………………..………. Telephone No: ………………………………………………………….

Address : ………………………………………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………………………………………………

Is there any medical attention you would NOT like your child to receive, or anything that we should make the hospital aware of? ………………………………………………………………………………………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………….…………………………………………………………………………………..

I give permission for my child ……………………………………..……………………………………………..….. to receive medical attention as needed whilst in the care of the school.

Name of Parent/Carer: …………………………………………………………………………………………………………………………………………………………..…….

Signed: ….…………………………………………………………………………………………………….… Dated:…………………………………………………………………