# ANNEXE VIII: AUTHORISATIONS AND PERMITS

## A. SPORTS AND CULTURAL TRIP MEDICAL FORM

| A. PUPIL INFORMATION |
|---|
| Surname/s:……. Name……..... |

| B. HISTORY OF ILLNESSES |
|---|
| _____ |

| C. SURGICAL OPERATIONS |
|---|
| _____ |

| D. DECLARES ANY IMPEDIMENT OR INCAPACITY PREVENTING HIM FROM UNDERTAKING SPORTING ACTIVITIES? |
|---|
| Where affirmative, state the reasons _____<br>_____ |

| E. OBSERVATIONS OF INTEREST: ALLERGIES, ETC. |
|---|
| _____ |

| F. AUTHORISATION FOR THE ADMINISTRATION OF ANTIPYRETICS TO PUPILS |
|---|
| As the father, mother or guardian of the pupil: _____ of the course _____ I hereby authorise and request, under my responsibility, that, where required, the teaching staff of Bell-lloc administer **AN ANTIPYRETIC,** to my child (Ibuprofen, Dalsy, Paracetamol Apiretal, Gelocatil), in the dosage appropriate to age and weight**.** |

| G. AUTHORISATION FOR EMERGENCY MEDICAL CARE |
|---|
| Mr./Mrs./Ms._____<br>With ID nº_____ as the father, mother or guardian of the pupil: _____I hereby authorise the teacher or coach of Bell-lloc, under my responsibility, and while the parents cannot be located, to provide authorisation for the appropriate emergency medical procedures to be undertaken, if considered necessary by healthcare personnel. |

The signature of the parents

..... (DAY), .....(MONTH). ..... 20.....

## B. SCHOOL MEDICAL FILE

| A. PUPIL INFORMATION |
|---|
| Surname/s:……. Name……..... |

| B. HISTORY OF ILLNESSES |
|---|
| _____ |

| C. SURGICAL OPERATIONS |
|---|
| _____ |

| D. MEDICATION TAKEN TO BE TAKEN INTO CONSIDERATION |
|---|
| Where affirmative, detail:<br>Medication:_____<br>When taken:_____<br>Dose:_____ |

| E. OBSERVATIONS OF INTEREST: ALLERGIES, ETC. |
|---|
| _____ |

| F. AUTHORISATION FOR THE ADMINISTRATION OF ANTIPYRETICS TO PUPILS |
|---|
| As the father, mother or guardian of the pupil: _____ of the course _____ I hereby authorise and request, under my responsibility, that, where required, the teaching staff of Bell-lloc administer **AN ANTIPYRETIC,** to my child (Ibuprofen, Dalsy, Paracetamol Apiretal, Gelocatil), in the dosage appropriate to age and weight**.** |

Mr./Mrs./Ms _____

With ID nº_____

The signature of the parents

.....(DAY), .....(MONTH). ..... 20.....