Child's Name_____

If your child has allergies, please tell us what they are and the severity of their reaction.

Food Allergy Severity:

High Moderate Low None

Food Allergy description, medication and treatment:

Allergy to medicines:

High Moderate Low None

Bee Sting Allergy Severity

High Moderate Low None

Bee sting medication and Treatment

Does your child wear:

Glasses? Hearing Aid?

Please provide any special information regarding the wearing of glasses or hearing aides

Please provide any further medical information or special instructions regarding the health and well-being of your child

Authorisations:

Minor Medical Treatment

I herby give my permission for the Horizons Oscar staff to treat my child if a minor accident occurs. In the case of a more urgent matter I understand an ambulance will be called first then I will be notified.

☐ Please tick here if you have read, understood and agree to the above statement

Prescribed Medication

I herby give permission to the staff of Horizons Oscar programme to administer medically prescribed medication to my child. I understand that the staff will record each administration of medication. I acknowledge that all care will be taken and I will not hold Horizons Oscar responsible.

☐ Please tick here if you have read, understood and agree to the above statement

Self Medication

I herby notify Horizons Oscar that my child carries medication with them and will self-medicate when necessary. I understand that my child is to let staff know when they self-medicate so that a record may be kept and any further instructions followed.

☐ Please tick here if you have read, understood and agree to the above statement

Parent/Caregiver(s) signature: …… Date: ……..

Horizons Oscar Supervisor Name :…… Date: ……..