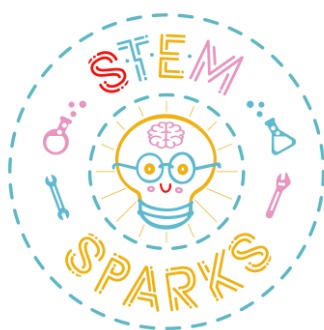


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BOOKING & CONSENT FORM

(If more than one child you can simply photocopy, complete and attach additional sheets with child's details)

1. Name of Child: _____

Date of Birth: _____

Age: _____ Year group: _____

Medical Condition(s) of Concern: _____

Signs and/or Symptom(s) to Watch for: _____

List the Child's Medications, Prescription and Over-the-Counter:

Medication: _____ Dose: _____

How Given: _____ When Given: _____

Special Instructions (to be taken with, etc.): _____

Possible Side Effects: _____

Medication: _____ Dose: _____

How Given: _____ When Given: _____

Special Instructions (to be taken with, etc.): _____

Possible Side Effects: _____

Who will be collecting your child: _____

Collection Password (Optional): _____

I give permission for Stem Sparks Ltd authorised first aider to administer medicine to the child named above in the manner described above.

Where the activity Co-Ordinator is unable to contact me or it is otherwise impracticable to contact me, I authorise to:

- consent to my child receiving such medical or surgical attention as may be deemed necessary by medical practitioner.
- administer such first-aid as may judge to be reasonably necessary.
- take the appropriate measures including contacting emergency services and arranging for transportation by ambulance to the nearest hospital to receive the appropriate level of care as determined by qualified medical professionals.

Parent/Legal Guardian's Name: _____

Contact Numbers: _____ on _____ (hours/days)

_____ on _____ (hours/days)

Parent/Legal Guardian Signature: _____ Date: _____