# CONSENT FORM

**Name + Surname student: _____ Class:_____**

- **In the event of a nuclear emergency occurring during school hours**, on the recommendation of the Ministry of Public Health or Provincial Governors

  I authorise staff to administer an iodine tablet to my child in the event of a nuclear emergency

  Yes □ No □

- **In the case of a health emergency involving bacterial meningitis,**

  □ I authorise the school doctor and medical team to administer the following treatment to my child:

  prophylaxis against bacterial meningitis if deemed necessary (Ciprofloxacin)

  □ I do not authorise the school doctor and the medical team to administer to my child the

  prophylactic treatment against bacterial meningitis and undertake to:

  - pick up my child as soon as possible and have them prescribed appropriate treatment

    by the treating physician;

  - provide a certificate from the treating physician that the treatment has been administered and

    that the student can return to school.

Any student who has not received this medication should be kept out of school for 7 days from the last risky contact.

You will find all the information on iodine in case of nuclear emergency and bacterial meningitis on the school website under the heading "Medical Service".

- **In the case of any other significant health problem in your child for which communication between the school doctor and the General Practitioner /specialist would be useful,**
  I authorise the school doctor to contact the attending doctor / specialist, in accordance with medical confidentiality

  Yes □ No □

This document is valid for the duration of your child's schooling in our establishment and will be kept in his/her medical file in order to preserve the confidentiality of information.
If you wish to withdraw your consent, please notify us by e-mail at BRK-INFIRMARY@eursc.eu

I, the undersigned (Name and First Name) :

Date and signature :