**OBUHSN-24 Appendix 2: Risk assessment form**

|  |  |  |  |
| --- | --- | --- | --- |
| Field course title |  |  |  |
| Duration |  | To |  |
| Description of activities |
| Number of Students |  | Number of Staff |  |
| Itinerary |
| Method of travel |  |
| Pick-up point(s) |  |
| Special points of safety with risk category, High, Medium or Low H,M or L |
|  |  |
| Accommodation address(s) | Telephone Number(s) |
| What type of evaluation of accommodation has been carried out? The evaluation should include security, quality of welfare facilities and fire safety arrangements. |  |
| Have all participants been issued with and signed for a copy of "Codes of Practice for Safe Working" |  |
| Will students be at any time working away from the main group. |  |
| Has a pre-course briefing been carried out |  |
| Have all students completed a next of kin form |  |
| EMERGENCY CONTACT NUMBERS AT OXFORD BROOKES UNIVERSITY |
| Calls from with the UKSite Services Manager (01865) 483059Site Services shift control manager (01865) 483060Student Services (01865) 484650 | International calls+ 44 (0) 1865 483059+ 44 (0) 1865 483060+ 44 (0) 1865 484650 |
| Any other information |
| Signed............................................................................(Course Leader)Print………………………………………………………Signed............................................................................(Dean of School / Director of Directorate)Print………………………………………………………Signed............................................................................(Safety Officer)Print……………………………………………………… | Date.................................Date.................................Date................................. |
| **CONFIDENTIAL** Staff/Student Emergency Contact form (only to be used in an emergency) |
| Name | Staff/Student No |
| Local Address | Home Address |
| Field Course Title |
| Telephone Number | Telephone Number |
| Personal Tutor | Fields  | Date  |
| Name and address of contact person |  Telephone No |
| Current GP's NamePractice Address | Telephone No |
| Do you suffer from any of the following? Delete as appropriate |
| Asthma or Bronchitis | YES | NO | Allergies to any drugs | YES | NO |
| Heart Condition | YES | NO | Any other Allergies | YES | NO |
| Fits, Fainting or Blackouts | YES | NO | Other illness or disability | YES | NO |
| Severe headaches | YES | NO | Severe travel sickness | YES | NO |
| Diabetes | YES | NO | Back or knee problems | YES | NO |
| Are you receiving medical or surgical treatment from a doctor/hospital. | YES | NO |
| Have you been given specific medical advice to follow related to the above. | YES | NO |
| If the answer to any of the above questions is YES, please give details here: |
| In preparation for your planned field trip have you ensured that you have had the appropriate vaccinations for: (a) the work you are undertaking, (b) the destination of travel. If your response is no, you are strongly recommended to seek medical advice **before** your departure. | YES | NO |
| Please advise if you have any special dietary requirements |
| Signed: | Date: |