

PARENTAL CONSENT FORM

CONFIDENTIAL

(To be distributed with full details of the visits)

CONSENT FOR PARTICIPATION IN THE OFF-SITE VISIT:

Visit to:

Date/Time: From To

I agree to my son/daughter (**name**) taking part in the above visit. I have received and read details of the above visit, and agree to his/her participation in any or all of the activities outlined in the letter to parents apart from (**see 1.1 below**). I acknowledge the need for obedience and responsible behaviour on his or her part. I understand that as part of the planned transport arrangements, and in an emergency, it may be necessary for young people to be transported in staff vehicles.

1.1. If there are any activities, in which your child cannot participate, please give details:

If water activities are involved, is your child confident in water?

Yes ☐

No ☐

N/A

☐

MEDICAL INFORMATION, DECLARATION AND CONSENT:

In your child's interest, it is important that the school should know whether he or she has any illness or medical condition.

2.1 Son/daughter's date of birth:/...../.....

2.2 Does your child suffer from any conditions of which the teacher leading the visit should be aware?

Yes ☐

No ☐

N/A ☐

If **yes**, please give details, e.g. illness, travel sickness, allergies, etc:

2.3 Details of any medication:

Name of medication	Dosage	Times of day or circumstances to be given	Method of administration

I give my consent** for a member of staff to administer the above medication which I will deliver to the Visit Leader before the visit. I understand the staff leading the visit are not qualified practitioners but that they will take reasonable care in the administration of the medication and will endeavour to respond appropriately should emergency treatment be required.

I give my consent** for my son/daughter to self-administer the above medication.

** delete if not applicable

continue over

MEDICAL INFORMATION, DECLARATION AND CONSENT (continued):

- 2.4. To the best of your knowledge, has your son/daughter been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be, or become, contagious or infectious?

Yes ☐No ☐N/A ☐

If **yes**, please give brief details:

- 2.5. Is your son/daughter allergic to any medication?

Yes ☐No ☐N/A ☐

If **Yes**, Please specify

- 2.6. When did your son/daughter last receive a tetanus injection?/...../.....

- 2.7. Please outline below any special dietary requirements of your child:

- 2.8. I undertake to inform the Visit Leader/Head Teacher as soon as possible of any changes in the medical or other circumstances between now and start of the visit.

- 2.9. I agree to my son/daughter receiving emergency medical treatment, including anaesthetic and blood transfusion, as considered necessary by the medical authorities present.

CONTACT TELEPHONE NUMBERS:

- 3.1. I may be contacted by telephoning the following numbers:

Work telephone no: Home telephone no:

Home address:
.....

- 3.2. If I am not available, please contact:

Name: Home telephone no:

Home address:
.....

- 3.3. **Family Doctor:**

Name: Home telephone no:

Address:
.....

ANY OTHER RELEVANT INFORMATION:

SIGNATURE:

DATE:

FULL NAME (capitals):