

**PLEASE COMPLETE AND RETURN
TO THE SCHOOL OFFICE ASAP**

**EDUCATIONAL VISITS: FORM SV 5
PARENTAL CONSENT FORM**

**CONFIDENTIAL –
CONSENT FOR PARTICIPATION IN ALL OFF-SITE VISITS
FROM ST AIDAN'S RC FIRST SCHOOL:**

CLASS _____

2015-2016

I agree to my son/daughter (**name**) _____ taking part in all off-site visits during 2015 – 2016. I understand that I will receive details of each visit before it takes place, and agree to his/her participation in any or all of the activities described, (**see 1.1 below**). I acknowledge the need for obedience and responsible behaviour on his or her part. I understand the extent and limitations of the insurance cover provided. 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.

If any details on this form change during 2015 - 2016, I will ensure that I contact the school office to complete a new parental consent form.

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 group 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:

* I give my consent to my child being photographed/filmed for educational purposes and for photographs, footage to be used for publicity purposes (i.e. school documents, educational websites, press, media etc.) (Please delete this statement* if you do not give consent)

SIGNATURE: _____

DATE: _____

FULL NAME (capitals): _____