**OFF-SITE VISIT PARENTAL CONSENT FORM**

**CONFIDENTIAL INFORMATION**

Information given on this form will not prejudice the inclusion of your child on the trip.

It is essential to complete this form accurately in the interests of your child’s safety.

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| **Pupil’s surname** | **Pupil’s forenames** |
| **Gender** | **Class** | **DoB:** | **Age on departure** **Years Months** |
| **Visit to** | **Date:**  |

To ensure that parents may be contacted if necessary – please complete the following:

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| --- | --- |
| First Contact – parent / legal guardian:Name:Home address:E:mail: | Telephone numbersHome:Work:Mobile: |
| Parents’ address if different during the visit: | Telephone numbersHome:Work:Mobile: |
| Second contact – eg family member / neighbour/friendName:Relationship:Address: | Telephone numbersHome:Work:Mobile: |

Please give your family doctor’s Name, Address and Telephone Number.

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| Doctor’s Name: | Doctor’s Telephone Number: |
| Doctor’s Address: |

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| Can your child swim 50 metres? YES/NO |
| Does your child follow a special diet? (If yes please give details) |
| Does your child have any condition requiring medical treatment, including medication? Please give details: |
| Immunisation status.Is your child vaccinated against Tetanus?  YES/NO | Date of injection | Booster |
| Please give details of any other relevant vaccinations: |
| If your child has recently been exposed to any infectious diseases he/she should be examined by a doctor and a letter of fitness to participate must be issued. |
| Has your child suffered from any of the following? | Allergies YES/NO |
| Asthma or Bronchitis YES/NO | Recent Fracture or Ligament Damage YES/NO |
| Heart condition YES/NO | Fits, Fainting or Blackouts YES/NO |
| Severe Headaches or Migraine YES/NO | Diabetes YES/NO |
| Haemophilia YES/NO | Sleep walking YES/NO |
| If you’ve answered YES to any of the above, please provide further details: |
| Any other illness or disability? Please give details: |
| I would like my daughter/son to keep her/his medication with her/him for use as necessary: Name of medicine:Normal use:Procedure in case of emergency: (not applicable) |
| I would like group leaders to keep medication for my child during the trip, and administer as necessary. I understand that there will be a more detailed form to complete prior to trip departure.Name of medicine: Initialled: \_\_\_\_\_\_\_\_\_\_\_\_\_ (*Parent – Legal Guardian.)* (not applicable) |

I wish my son/daughter to take part in the above mentioned visit and having received relevant information, agree to him/her taking part in the activities described. I have discussed the visit with my son/daughter who understands the requirements which have to be observed.

I shall instruct my child to wear a seat-belt whilst travelling by motor vehicle and to abide by any other safety instruction and behavioural requirements.

In the event that your child requires medical attention, the trip leader will make every attempt to contact the nominated people below in the first instance. If they are unobtainable I give permission for the member of staff to have legal duty of care for my child.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Parent – Legal Guardian.*