PARENTAL CONSENT FOR A VISIT

Including consent for swimming activities or activities where being able to swim is essential

(*To be distributed with an information sheet giving full details of the visit)*

Student name: …… Form: ……. Date of Birth: ……...

1. **Details of visit to**: _____

   From: _____ **Date/Time**: _____ **To**: _____ **Date/Time**: _____

   I agree to ……..…… (name) taking part in this visit and have read the information sheet. I agree to ……..……'s participation in the activities described, including swimming. I acknowledge the need for them to behave responsibly.

2. **PRIMARY CONTACT INFORMATION**

   Name: ……...

   Address: …… **Home Telephone №:** ……..

   …… **Work Telephone №:** ……

   …… **Mobile №:** ……..

   Other Emergency Contact

   Name: …… **Telephone №:** ……...

   Address: ……...

   ……

3. **FOR RESIDENTIAL VISITS AND EXCHANGES ONLY**

   - 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 contagious of infectious?

     YES ☐ NO ☐

   If YES, please give brief details: _____

   _____

   - Is your son/daughter allergic to any medication? YES ☐ NO ☐

   If YES, please give brief details: _____

   _____

   - Can your child swim? YES ☐ NO ☐ How far? _____
   - Is your child water confident in a pool? YES ☐ NO ☐
   - Is your child safety conscious in the water? YES ☐ NO ☐

   I confirm that my child is in good health and I consider him/her fit to participate. **Please sign here: _____**

   - When did your son/daughter last have a tetanus injection? _____

MEDICAL INFORMATION – Part One

1. Any conditions requiring medical treatment, including medication? Yes ☐ No ☐

   Please give brief details of the condition: _____

   _____

   _____

2. Please outline any special dietary requirements of your child: _____

   _____

   _____

MEDICAL INFORMATION – Part Two

THIS PART TO BE COMPLETED BY PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT DRUGS BE ADMINISTERED UNDER SUPERVISION OF SCHOOL STAFF OR WHERE A CHILD IS BRINGING MEDICINE INTO SCHOOL WHICH THEY WILL SELF ADMINISTER.

Name of child: …… **Date of Birth:** ……

Address: ……...

……

…… **Postcode:** ……

School: ……

Doctor's name and Surgery address: ……..

……

…… **Telephone №:** ……

Non-prescribed medicines - My child requires the following non-prescribed medicines: -

_____ _____

_____ _____

_____ _____

Prescribed medicines - The Doctor has prescribed the following for my child:-

	Name of drug or medicine to be given and any special storage instructions	When? E.g. lunchtime, after food, when wheezy, before exercise	How much? E.g. half a teaspoon, 1 tablet, 2 drops	Route? E.g. by mouth, in ear
1				
2				
3				
4				

Child's name: …… **can/cannot*** administer their own medication; **does/does not*** require **supervision/assistance*** in administering their own medicine. *(* **delete where applicable**)*

I request that the treatment be given in accordance with the above information by a named member of the school staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.

I undertake to supply the school with the drugs and medicines in the original duplicate labelled containers, provided by the Dispensing Chemist.

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent and that the school staff may, therefore, need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

I will inform the Group Leader/Headteacher as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.

DECLARATION

I agree to my son/daughter receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present. I understand the extent and limitations of the insurance cover provided.

Signed: …… *(Parent/Carer)* **Date:** ……

Full name (capitals): ……

This form or a copy must be taken by the Group Leader on the visit and a copy should be retained by the school contact.