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|  | PARENT/GUARDIAN CONSENT FORM | FORM P9 |
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| School/Group: | Year 3 & Year 5 swimming |

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| **1.** | **Details of visit to:** | Knowsley Leisure & Culture Park |  |
|  |
|  | From: | 9am | Date/ | 11.3.13 | To: | 12 noon (approx) | Date/Time: | 21.3.13 |  |
|  |  |
|  | I agree to |  | (name) taking part in this visit and  |  |
|  |
|  | have read the information sheet provided. I agree to |  | ‘s |  |
|  |
|  | participation in the activities described. I acknowledge the need for |  |  |
|  |
|  | to behave responsibly and that I may be required to collect them/meet the cost of them being |
|  |
|  | transported home should they breach conduct or safety rules whilst on the visit/activity. |
|  |
| **2.** | **Medical information about your child** |  |
|  |
|  | a. | Any conditions requiring medical treatment, including medication? | YES | NO |  |
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|  |  | If YES, please give brief details: |  |
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|  | *SWIMMING ABILITY** *Is your child able to swim 50 metres? YES/NO/*
* *Is your child water confident in the pool? YES/NO/*
* *Is your child safety conscious in water? YES/NO/*

*1. I would like \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) to take part in the swimming activities.**2. I consent to any emergency medical treatment required by my child to be administered during the course of the visit.**3. I confirm that my child is in good health and I consider him/her fit to participate.* |  |
|  | 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. |  |
|  |
| **3.** | **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.  |  |
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|  | Contact telephone numbers: |  |
|  |
|  | Work: |  | Home: |  |  |
|  |
|  | Home Address: |  |  |
|  |
|  |  |  |  |
|  |
|   | Alternative Emergency Contact: |  |
|  |
|  | Name |  | Tel: |  |  |
|  |
|  | Address: |  |  |
|  |
|  |  |  |  |
|  |
|   | Family Doctor: |  |
|  |
|  | Name |  | Tel: |  |  |
|  |
|  | Address: |  |  |
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|  |  |  |  |
|  |
|  | Signed: |  | Date: |  |  |
|  |
|  | Full Name (capitals): |  |  |
|  |