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|  | PARENT/GUARDIAN CONSENT FORM | FORM P9 |
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| School/Group: |  |

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| **1.** | **Details of visit to:** | | | |  | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | |
|  | From: | |  | | | Date/Time: |  | To: | | |  | Date/Time: | | | |  | | |  | |
|  | | | | | | | | | | | | | | |  | | | |
|  | I agree to | | |  | | | | | | (name) taking part in this visit and | | | | | | | | |  | |
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|  | have read the information sheet provided. I agree to | | | | | | | |  | | | | | | | | ‘s | |  | |
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|  | participation in the activities described. I acknowledge the need for | | | | | | | | | | |  | | | | | | |  |
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|  | to behave responsibly and that I may be required to collect them/meet the cost of them being | | | | | | | | | | | | | | | | | | |
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|  | 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 | | | |  | |
|  | | | | | | | | | | | | | | | | | | | |
|  |  | If YES, please give brief details: | | | | | | | | | | | | | | | |  | |
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|  | b. | Please outline any special dietary requirements of your child and the type of pain/flu | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | |
|  |  | relief your child may be given if necessary: | | | | | | | | | | | | | | | |  | |
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|  | For residential visits and exchanges only | | | | | | | | | | | | | | | | |  | |
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|  | c. | 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 or infectious? | | | | | | | | | | | YES | NO | | | |  | |
|  | | | | | | | | | | | | | | | | | | | |
|  |  | If YES, please give brief details | | | | | | | | | | | | | | | |  | |
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|  | d.. | Is your son/daughter allergic to any medication? | | | | | | | | YES | NO |  |
|  | | | | | | | | | | | | |
|  |  | If YES, please specify: | | | | | | | | | |  |
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|  | e. | When did your son/daughter last receive a tetanus injection? | | | | | | | | | |  |
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|  | 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. | | | | | | | | | | |  |
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| **3.** | **Declaration** | | | | | | | | | | |  |
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|  | 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. | | | | | | | | | | |  |
|  | | | | | | | | | | | | |
|  | Contact telephone numbers: | | | | | | | | | | |  |
|  | | | | | | | | | | | | |
|  | Work: | |  | | | Home: | |  | | | |  |
|  | | | | | | | | | | | | |
|  | Home Address: | | |  | | | | | | | |  |
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|  | | | | | | | | | | | | |
|  | Alternative Emergency Contact: | | | | | | | | | | |  |
|  | | | | | | | | | | | | |
|  | Name | |  | | | Tel: | |  | | | |  |
|  | | | | | | | | | | | | |
|  | Address: | | |  | | | | | | | |  |
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|  | Family Doctor: | | | | | | | | | | |  |
|  | | | | | | | | | | | | |
|  | Name | |  | | | Tel: | |  | | | |  |
|  | | | | | | | | | | | | |
|  | Address: | | |  | | | | | | | |  |
|  | | | | | | | | | | | | |
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|  | | | | | | | | | | | | |
|  | Signed: | |  | | | | Date: | |  | | |  |
|  | | | | | | | | | | | | |
|  | Full Name (capitals): | | | |  | | | | | | |  |
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