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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  |  |
|  |
|  | 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 |  |
|  |
|  |  | 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 |  |
|  |
|  | 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? |  |
|  |
|  |  |  |  |
|  |
|  | 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. I understand the extent and limitations of the insurance cover provided. |  |
|  |
|  | Contact telephone numbers: |  |
|  |
|  | Work: |  | Home: |  |  |
|  |
|  | Home Address: |  |  |
|  |
|  |  |  |  |
|  |
|   | Alternative Emergency Contact: |  |
|  |
|  | Name |  | Tel: |  |  |
|  |
|  | Address: |  |  |
|  |
|  |  |  |  |
|  |
|   | Family Doctor: |  |
|  |
|  | Name |  | Tel: |  |  |
|  |
|  | Address: |  |  |
|  |
|  |  |  |  |
|  |
|  | Signed: |  | Date: |  |  |
|  |
|  | Full Name (capitals): |  |  |
|  |