PARENTAL CONSENT FOR A RESIDENTIAL VISIT - Nether Green Junior School

(to be distributed with full details of the visit)

1. Details of visit to:

From (date/time): To (date/time):

Name of Child: _____ Class: _____

I agree to my child's participation in the following activities… map work skills, a geographical study of the local area, team building tasks, problem solving activities and sports.

Yes ☐

I acknowledge the need for my child to behave responsibly and follow instructions.

Yes ☐

2. Medical Information about your child

a) Date of birth of your child: _____

b) Does your child suffer from any conditions which the visit leader needs to be aware of, for example: medical conditions, illness, allergies, night time tendencies (sleepwalking, bedwetting, nightmares), travel sickness etc? **Yes** ☐ **No** ☐

c) If yes, please provide details:

d) Does your child take prescribed medication? **Yes** ☐ **No** ☐

e) If yes, please give details, including how medication is administered, including details of medication timings, dosage and any side effects:

f) Please outline any special dietary requirements of your child including vegetarian, vegan, dairy free, halal, gluten/wheat intolerance etc.

g) To the best of your knowledge, has your child 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 ☐**

h) If yes, please give details:

i) Is your child allergic to any medication? **Yes ☐ No ☐**

j) If yes, please specify:

k) When did your child last have a tetanus injection? _____

l) I will inform the teacher/ head teacher as soon as possible of any changes in medical or other circumstances between now and the commencement of the visit. **Yes ☐**

m) I give permission for the class teacher to administer Calpol to my child, if considered necessary, during this residential visit. **Yes ☐ No ☐**

n) In an emergency I consent to my child 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.
Yes ☐ No ☐

3. Special educational needs and disabilities

If your child has any special educational needs and/or disabilities which the school needs **further** information about for this visit, please outline them here indicating how they may be supported:

4. Contact information

I can be contacted using the following telephone numbers:

Full name (capitals) _____

Home/Mobile: _____ Work: _____

Home address: _____

Alternative contact (name) _____ Telephone number: _____

Relationship to pupil: _____

Name of family doctor: _____ Telephone number: _____

Address: _____

5. I consent to my child taking part in this visit:

Signed Parent/Carer: _____ Print name: _____

Date: _____