



St Patrick's
Catholic Voluntary Academy

ST. PATRICK'S CATHOLIC VOLUNTARY ACADEMY.

Coronation Avenue, Wilford, Nottingham NG11 7AB

☎ 0115 9152961

Email: admin@st-patricks.nottingham.sch.uk

Website: www.st-patricks.nottingham.sch.uk



**OUR LADY
OF LOURDES**

CATHOLIC MULTI-ACADEMY TRUST

Headteacher: Miss L Ferrara

Monday 29th April 2024

Dear Parents/Carers,

Year 4 Nottingham Cave Explorers

To supplement Year 4's exciting new local site study of the Nottingham Caves topic in Pentecost 1, children will have an opportunity to attend the National Justice Museum for an exciting day exploring the history and architecture of the Nottingham caves! This trip will take place on Tuesday 14th May 2024, with us leaving school at 11:30am and returning for the normal end of day collection time.

Your child will need to bring a packed lunch (no glass bottles or fizzy drinks) with them on the trip day. However, if your child is eligible for free school meals, a packed lunch will be provided by the school but you will need to provide them with a drink please.

With the date fast approaching, we wanted to keep families informed of what pupils will be taking part in in the coming Pentecost term. There are no monetary contributions required for this fantastic learning experience as the school will be covering the costs.

Kind Regards,

Miss Sutton
Year 4 Class Teacher



ST PATRICK'S CATHOLIC VOLUNTARY ACADEMY

OV4 CONFIDENTIAL CONSENT FORM FOR YOUNG PEOPLE

1. CONSENT FOR PARTICIPATION IN THE VISIT:

Name of Establishment/Group: **St Patrick's Catholic Voluntary Academy**

Visit to: **Year 4 Trip to Nottingham Caves at the
National Justice Museum in Nottingham**

Details Activities to be undertaken: **Various activities**

Date(s) / Times: **Tuesday 14th May 2024**

I agree to my son/daughter: _____ **(name)** taking part in the above-mentioned visit and, having read the information provided, agree to his/her participation in any or all of the activities* described. I acknowledge the need for obedience and responsible behaviour on his/her part. I understand the extent and limitations of the insurance cover provided.

*If there are any activities in which your child cannot participate, please give details: _____

2. MEDICAL INFORMATION, DECLARATIONS AND CONSENT:

a) Son/daughter's date of birth: _____

b) Does your son/daughter suffer from any conditions of which the staff leading the visit should be aware:

YES / NO

Please give details of anything the leader needs to know about to safety care for your child e.g. illness, travel sickness, allergies, night-time tendencies (sleepwalking, nightmares, bed-wetting) etc: _____

c) Details of any medication

Name of medication	Dosage	Times of day or circumstances to be given	Method of administration

Any special precautions, side effects of medication etc: _____

I give my consent ** for a member of staff to administer the above medication which I will deliver to the group leader before the visit. I understand the staff leading the visit are not qualified medical practitioners but that they will take reasonable care in the administration of the medication and will endeavor to respond appropriately should emergency treatment be required.

I give my consent ** for son/daughter to self-administer the above drugs.

**** Delete if not applicable**

d) 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, or become, contagious or infectious?:

YES / NO

If **YES**, please give brief details: _____

e) Is your son/daughter allergic to any foods or medication:

YES / NO

If **YES**, please specify: _____

f) When did your son/daughter last receive a tetanus injection?: _____

g) Please outline any special dietary requirements of your child: _____

h) **I undertake** to inform the group leader/head of establishment as soon as possible of any change in the medical or other circumstances between now and the commencement of the journey.

i) **I agree** to my son/daughter receiving emergency medical treatment, including anaesthetic and blood transfusion, as considered necessary by the medical authorities present.

3. CONTACT NUMBERS:

a) I may be contacted by telephoning the following numbers:

Work: _____ Home: _____

My home address is: _____

b) If not available at home, please contact:

Name: _____ Telephone Number: _____

Address: _____

c) Name, address and telephone number of family doctor: _____

4. ANY OTHER RELEVANT INFORMATION:

5. SIGNATURE:

Signed: _____ Date: _____

Full name (capitals): _____ Parent/Guardian

1 copy to be held by the Establishment
1 copy to be taken by Leader on the visit