



St Patrick's
Catholic Voluntary Academy

ST. PATRICK'S CATHOLIC VOLUNTARY ACADEMY.

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Headteacher: Miss L Ferrara



5th November 2024

Dear Parents and Carers,

Years 1 & 2- Storm Whale production trip

This half term we will be watching the Storm Whale production at the Lakeside Arts Theatre at University Park, Nottingham on Thursday 19th December at 1:30 pm. This is one of the books covered in our learning and is an excellent opportunity to visit a theatre, engage in the arts, develop our storytelling and learn new vocabulary ready for when we introduce the book in our learning.

The cost of this trip has been covered by school funds, so no contributions are needed. The production is in the afternoon therefore we will be having an early lunch at school and leaving shortly after to travel by coach to and from the Lakeside Arts Theatre. We will arrive back at school in time for the end of the school day.

Please fill in the attached consent form and return it to school office by Monday 18th November.

Kind regards

Mr Ward and Miss Elton
Year 2 and Year 1 Teachers



ST PATRICK'S CATHOLIC VOLUNTARY ACADEMY

OV4 CONFIDENTIAL CONSENT FORM FOR YOUNG PEOPLE

1. CONSENT FOR PARTICIPATION IN THE VISIT:

Name of Establishment/Group: **Years 1 & 2 St Patrick's Catholic Voluntary Academy**

Visit to: **Visit to Lakeside Arts Theatre, University Park, Nottingham**

Details of Activities to be Undertaken: **Storm Whale Production**

Date(s) / Times: **Thursday 19th December 2024 at 1.30pm**

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