



**ST. PATRICK'S CATHOLIC VOLUNTARY ACADEMY.**  
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**Headteacher:** Miss L Ferrara

Tuesday 23<sup>rd</sup> September 2025

Dear Parents and Carers

**Year 6 Hub Mass - Friday 3<sup>rd</sup> October 2025**

Each year the Year 6's in our St Francis of Assisi Hub are invited to celebrate mass together with other Year 6's from our Trust Schools. This year the mass will be held on Friday 3<sup>rd</sup> October at Our Lady and St Edward's Church.

The children will come to school at normal time and transport has been arranged to take them to church for 10:30am. We will be back to school for lunchtime.

We ask that the children wear their normal school uniform on this day. They do not need to bring anything additional with them.

Please sign and complete the attached consent form and return this no later than Monday 29<sup>th</sup> September 2025.

Kind regards,

Mrs Davis  
Year 6 Class Teacher



Coronation Avenue, Wilford  
Nottingham, NG11 7AB  
Headteacher: Miss Luisa Ferrara

St Patrick's  
Catholic Voluntary Academy

Love First, Live the Gospels, Learn for Life



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## OV4 CONFIDENTIAL CONSENT FORM FOR YOUNG PEOPLE

### 1. CONSENT FOR PARTICIPATION IN MULTIPLE VISITS:

Name of Establishment/Group: **Year 6 - St Patrick's Catholic Voluntary Academy**

Visits to: **Attending Hub Mass at Our Lady and St Edwards Church, Nottingham**

Activities to be undertaken: **Attending Mass**

Dates: **Friday 3<sup>rd</sup> October 2025**

I agree to my son/daughter: \_\_\_\_\_ (name) taking part in local area visits (which may include using public or private hire transport) and agree to his/her participation in activities that will support the national curriculum. I acknowledge the need for obedience and responsible behaviour on his/her part.

Please note this consent form does not cover the following activities: swimming, water sports and activities or adventurous activities.

### 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, asthma, 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.

- 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