ST. PATRICK'S CATHOLIC VOLUNTARY ACADEMY.
Coronation Avenue, Wilford, Nottingham NG11 7AB
☎ 0115 9152961 **Fax** 0115 9152962
Email: admin@st-patricks.nottingham.sch.uk
Website: www.st-patricks.nottingham.sch.uk

Headteacher: Mrs J Cannell

Friday 11th September 2026

Dear Parents and Carers,

RE: Annual Consent Form For Trips and Visits

Please find enclosed an OV4 consent form.

This year we have made a change to our consent form to cover ***all trips*** that your child will go on throughout this academic year (excluding residential visits and swimming). We hope this will reduce the amount of paperwork that we need you to complete when your child attends a school trip.

It is therefore important that this form is completed in full and returned to us as soon as possible. Without this form on file, your child will not be able to take part in our local area visits or any other trips arranged by school.

Kind regards

St Patrick's School Office

St Patrick's
Catholic Voluntary Academy
Love First, Live the Gospels, Learn for Life

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

OUR LADY OF LOURDES

e: admin@st-patricks.nottingham.sch.uk
t: 0115 915 2961
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OV4 CONFIDENTIAL CONSENT FORM FOR YOUNG PEOPLE

1. CONSENT FOR PARTICIPATION IN MULTIPLE VISITS:

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

Activities to be undertaken: **Activities that will support the national curriculum.**

Dates: **Academic year 2026-2027**

I agree to my son/daughter:_____**(name) in Class** _____ taking part in trips and visits 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