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 T Lane

27th November 2017

Dear Parent/Carer,

Black Beauty at the Lakeside Theatre

We will be taking classes 3, 4 and 5 to see a production of Black Beauty at the Lakeside Theatre on Friday 15th December 2017 as part of the Christmas celebrations in school.

We will travel to the theatre by coach, the production will take place in the afternoon and the children will return for the end of the school day.

It should be a really fun and entertaining reward for the children's hard work this term. In order for the trip to go ahead we request a contribution of £3.50 towards the cost of the trip. I'm sure you'll agree this is very reasonable.

Please complete and return the attached OV4 consent form together with your contribution of £3.50 to the school office by Monday 4th December 2017.

Many thanks,

T Lane

Tracy Lane
Headteacher

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To The School Office, St. Patrick's Catholic Voluntary Academy

Black Beauty at the Lakeside Theatre

Name of Child ______________________________ Class __________

I enclose a contribution of £3.50

Signed ____________________ Parent/Carer of ______________________

ST PATRICK'S CATHOLIC VOLUNTARY ACADEMY

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: **Lakeside Theatre, University of Nottingham, Nottingham NG7 2RD**

Details Activities to be undertaken: **Watching performance of Black Beauty**

Date(s) / Times: **Friday 15th December 2017 (afternoon)**

I agree to my son/daughter:______________________________**(name)** taking part in the above-mentioned visit and agree to his/her participation. I acknowledge the need for obedience and responsible behaviour on his/her part.

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