



ST. PATRICK'S CATHOLIC PRIMARY & NURSERY VOLUNTARY ACADEMY
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Headteacher: Mrs T Lane

10.10.17

Dear Parents,

'CINDERELLA PANTOMIME – NOTTINGHAM PLAYHOUSE

Foundation Stage 2, Class 1 and Class 2 will be going to the Nottingham Playhouse to see the pantomime '**Cinderella**'. This will take place on **TUESDAY 12TH DECEMBER 2017** for the matinee performance at 2.30 pm and should finish at approximately 5.00 pm.



Children will have their lunch at school and travel by coach to the Playhouse returning to school at approximately 5.45 pm. This time cannot be precise due to the time of the performance ending and the amount of performance on that day.

Children will need to wear school uniform as normal. The children will be provided with a drink during the performance.

As usual, school tries to keep cost of visits as low as possible and a subsidy will be made towards the cost of the trip and therefore we are asking for a contribution of **£9.50 per child**.

Please complete the reply slip below and return with payment to school by **FRIDAY 20TH OCTOBER 2017**.

We are hoping for a most enjoyable time and we thank you for your continuing support.

Miss Sharkey
Class 2 Teacher

Miss Crich
Class 1 Teacher

Mrs Okanta
Foundation Stage 2 Teacher

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 To School Office, St. Patrick's Catholic Primary & Nursery School, Wilford

'CINDERELLA' PANTOMIME – NOTTINGHAM PLAYHOUSE

I enclose £9.50 for the cost of the pantomime trip on **TUESDAY 12TH DECEMBER 2017**



Signed _____ Parent 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: **Cinderella Pantomime at the Nottingham Playhouse**

Date(s) / Times: **Tuesday 12th December 2017**

I agree to my son/daughter: _____ (name) taking part in the above-mentioned visit. 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**