



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



Headteacher: Mrs T Lane

03 October 2017

Dear Parents

## **URGENT RESPONSE NEEDED – OV4 FORM FOR COMPLETION**

Please complete the attached OV4 form and return to school **before**  
**FRIDAY 6<sup>TH</sup> OCTOBER 2017.**

**PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY IF YOUR MOBILE NUMBER CHANGES AS WE MUST HAVE AN UP TO DATE CONTACT NUMBER FOR THE CHILDREN TO BE TAKEN OFF THE PREMISES.**

Kind Regards

A handwritten signature in black ink, appearing to read 'T Lane'.

T Lane  
Headteacher





# 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: **TAKE WALKS AROUND THE LOCALITY, TO CHURCH AND TO THE BECKET SCHOOL**

Details Activities to be undertaken: **VARIOUS ACTIVITIES TO SUPPORT LEARNING**

Date(s) / Times: From: **5<sup>TH</sup> SEPTEMBER 2017**

To: **25<sup>TH</sup> JULY 2018**

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: \_\_\_\_\_

I give permission for my son/daughter's name to be included in the collective passport to be held by the group leader: (please circle)

YES / NO / NOT APPLICABLE

If water activities are involved, is your child confident in water? (please circle)

YES / NO / NOT APPLICABLE

### 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