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 – Class 3**

Visit to: **Portland Leisure Centre, Muskham Street, Nottingham NG2 2HB**

Details Activities to be undertaken: **Swimming lessons on Thursdays**

Date(s) / Times: From: **Thursday 7th September to Thursday 14th December 2017**

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