



St Patrick's
Catholic Voluntary Academy

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



**OUR LADY
OF LOURDES**

CATHOLIC MULTI-ACADEMY TRUST

Headteacher: Mrs T Lane

20.9.19

Dear Parents/Carers

PLEASE COMPLETE THIS FORM FOR YOUR CHILD/REN

Please complete the attached consent form, this forms covers your child taking part in local area trips eg attending mass at church, secondary school visits and sport competitions with their class and teachers.

Please return this form to school.

Please contact the school office immediately if your mobile telephone number changes as we must have an up to date contact number for the children to be taken off the premises.

Many thanks

School Office



ST PATRICK'S CATHOLIC VOLUNTARY ACADEMY



OV4 CONFIDENTIAL CONSENT FORM FOR YOUNG PEOPLE

1. CONSENT FOR PARTICIPATION IN MULTIPLE VISITS:

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

Visits to: **Local area trips (e.g. attending mass at church, secondary school visits and sports competitions).**

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

Dates: **Academic year 2019 – 2020**

I agree to my son/daughter: _____ (name) taking part in local area 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