PARENTAL CONSENT FOR A SCHOOL VISIT
Please complete this form and return it to the visit organiser.

1. **Visit to**.....

From *Date*.....*Time*..... To *Date*..... *Time*.....

2. **Medical details**. My son/daughter has the following medical or special needs. .....

.....
.....
I understand that for residential visits I must complete and return a medical form, with up to date details, not more than fourteen days before the visit.

3. **Dietary details.** My son/daughter has the following dietary needs. .....

.....

4. **Insurance**. I understand the limits of insurance provided for this visit.

5. **Transport.** I understand the transport arrangements for this visit (***will involve travelling in other people's or staff cars***) and my child understands the need to wear a seatbelt.

6. **Return to Home.** I understand the predicted time of return and where this is outside normal school hours I will attend to collect my son/daughter or my son/daughter will be returning home by.....

7. **Water Activities and Swimming.** For visits that involve water activities and/or swimming my son/daughter's swimming ability and consent to partake is (tick boxes): -

Non-swimmer	
Swim less than 50 metres	
Swim 50 metres or more	
I consent to my son/daughter undertaking the water activities and swimming notified in the visit programme.	

I consent to my son/daughter swimming in open water	

8. **Financial Contribution.** I am willing to make a voluntary contribution of £..... which I either A) Enclose or B) Commit to pay by the advised date (delete as necessary).

9. **Photographs**. Photographs taken on the visit may be used in school or education service promotional information. Please answer Yes or No ..... ***(This may be omitted where the school already has a parental declaration regarding use of photographs).***

I agree to my son/daughter attending the visit (or series of visits) detailed above and I acknowledge that to be included he/she will need to maintain responsible behaviour.

Name of son/daughter ..... Class .....

Signed..... Date..... Person with Parental Responsibility

Telephone Number(s) ..... Date : .....

STAFFORDSHIRE COUNTY COUNCIL FORM EVM (2004)

MEDICAL FORM FOR YOUNG PEOPLE ATTENDING A RESIDENTIAL VISIT

To be completed by a person with parental responsibility not more than fourteen days prior to the starting date of the visit.

Name of child ..... Date of Birth .....

Address .....

..... Home Telephone No. .....

Name of parent or contact(s).....Relationship .....

Work Telephone No. ..... Mobile Telephone No. .....

Name of Child's Doctor .....

Doctor's Address & Telephone Number .....

.....

IF THE ANSWER TO ANY OF THESE QUESTIONS IS 'YES' PLEASE GIVE FULL DETAILS OVERLEAF

(Please circle the appropriate answer)

1. Will your child need to bring any medications for treatment during the visit?	YES	NO
2. Has your child suffered from, or been in contact with anyone suffering from, an infectious or contagious disease in the last four weeks?	YES	NO
3. Does your child suffer from?		
a) Epilepsy	YES	NO
b) Diabetes	YES	NO
c) Asthma	YES	NO
d) Bedwetting	YES	NO
e) Allergies (including to any medication)	YES	NO
4. Are there any restrictions upon participating in physical activities?	YES	NO

Has your child received an anti-tetanus injection? If 'yes' give date .....

I hereby give permission for my child to receive, if necessary, the following proprietary medications, at a dose appropriate to their age, to alleviate these complaints:

1. For colds causing congestion	Decongestant Lozenge (e.g. Tunes)
2. For headache	Paracetamol or Calpol
3. For insect/plant bites or stings	Spray or cream
4. For sore lips	Lip Salve or Vaseline
5. For sun protection	Sunscreen

I agree to my child receiving medication as instructed and any emergency dental, medical or surgical treatment including anaesthetic or blood transfusion as considered necessary by the medical authorities. I declare that I have answered all the above questions to be best of my ability and have not knowingly withheld any information regarding physical fitness. I undertake to inform the leader in charge of any changes to the above between the date signed and the start of the visit.

..... Date .....

(Person with parental responsibility sign and print name)

This medical form must be returned to the visit leader. The leader, or teacher in charge, will take the completed form on the visit. For visits to the County Outdoor Education Centres it will be handed in to the Centre Manager upon arrival.

THIS SECTION TO BE COMPLETED ONLY IF THE ANSWER TO ANY QUESTION OVERLEAF IS 'YES'

1. Give details of any medical treatment needed during the visit or medications that need to accompany your child (e.g. Hayfever remedies). If regular medication is needed please ensure that sufficient is provided to last throughout the visit.

2. Nature of infectious disease and how contacted during the past four weeks:

3. If your child suffers from EPILEPSY, DIABETES, ASTHMA, please give FULL details below. These should include severity and frequency of attack, approximate date of the last attack and details of any medication taken regularly or kept for emergencies. (Confirmation of fitness to attend, from a doctor, may be required before affected participants are deemed suitable to attend some visits):

4. Bed-wetting – arrangements must be made by the person with parental responsibility to provide suitable bedding, which may be necessary in this event.

5. Condition casing restriction upon physical activities and relevant details:

6. Details of allergies, including reaction to painkillers, antibiotics, analgesic and other propriety medicines and reactions to types of food i.e. nuts.