PARENTAL CONSENT FORM
(*FOR RESIDENTIAL VISIT)*

DETAILS OF TRIP

Destination: Rookin House Lake District
Depart : Date: *14/06/21*
Return : Date: *17/06/21*
I agree to _____(Name) _____ (date of birth), taking part in this trip and have read the information sheet provided by the Party Leader (*Mr S Lewis*)
I agree to my child's participation in the activities described.
I acknowledge the need for _____ to behave responsibly.

MEDICAL INFORMATION

a) Does your child have any conditions requiring medical treatment or medication?
(If YES please give **specific** details of symptoms, medication, dosage etc.) **YES / NO**

_____
_____
_____

b) Please outline any special dietary requirements your child has.

_____
_____
_____

c) Does your child suffer from any forms of allergic reaction (e.g. Medication / Nuts / Stings)
(If YES please give **specific** details of symptoms, medication, dosage etc.) **YES / NO**

_____
_____
_____

d) To the best of your knowledge, has your child been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be contagious or infectious?
(If YES please give **specific** details of symptoms, medication, dosage etc.) **YES / NO**

_____
_____
_____

e) Has your child required hospital treatment or been referred to a specialist in the last 2 years?
(If YES please give **specific** details.) **YES / NO**

_____
_____
_____

f) Has your child ever had a heart or circulatory related problem, a stroke, cancer, breathing problems or diabetes? (If YES please give **specific** details.) **YES / NO**

_____
_____
_____

g) When did your child last have a tetanus injection? _____

Name of Pupil's Doctor:_____
Address: _____
_____
_____

Contact Number:_____

I WILL INFORM THE PARTY LEADER / HEADMISTRESS AS SOON AS POSSIBLE OF ANY CHANGES IN THE MEDICAL OR OTHER CIRCUMSTANCES BETWEEN NOW AND THE COMMENCEMENT OF THE TRIP.

DECLARATION

I give permission for my child to receive the relevant dose of child paracetamol (Calpol) should the need arise.

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 present. I understand the extent and limitations of the insurance cover provided.

Signed_____Date_____
Full Name (capitals)_____

PARENTAL CONTACT DETAILS DURING RESIDENTIAL VISIT

1)
Name of Contact: _____
Relationship to Child: _____
Available FROM_____(Date) TO_____(Date)
Address: _____
_____
_____
_____
Contact Numbers: Home:_____
Work:_____
Mobile:_____

2)
Name of Contact: _____
Relationship to Child: _____
Available FROM_____(Date) TO_____(Date)
Address: _____
_____
_____
_____
Contact Numbers: Home:_____
Work:_____
Mobile:_____

3)
Name of Contact: _____
Relationship to Child: _____
Available FROM_____(Date) TO_____(Date)
Address: _____
_____
_____
_____
Contact Numbers: Home:_____
Work:_____
Mobile:_____