

PARENTAL CONSENT FOR AN EDUCATIONAL VISIT

Visit: Kingswood Grosvenor Hall, Ashford

Pupil's name: **Date of birth**.....

Class:.....

From: 15th May 2023 **To:** 19th May 2023

1. I agree to my son / daughter taking part in this visit and have read the information sheet and fully understand what is involved. I agree to his / her participation in the activities described. I acknowledge the need for and expect him / her to behave responsibly.

2. Medical/Health information about your child

- a. Please outline any special dietary requirements of your child.

.....
Does your child have any allergies? Please outline these below

- b. Does your child require travel sickness medication? If so, please give details below

- c. **Any Medical Conditions/Illnesses requiring medical treatment, including medication?**
YES/NO (If Yes, please give details below

d. **Regular, Prescribed Medication**

Name/Type of Medication (See container).....

Health condition this medicine has been prescribed for.....

How long will this medicine need to be administered for?.....

Date Dispensed.....Expiry Date.....

The above medication(s) have been prescribed by a doctor. It is clearly labelled indicating contents, dosage and child's name in full.

Name of Prescribing Doctor.....

Address of Prescribing Doctor.....

Telephone Number of Prescribing Doctor.....

e. **Directions for Use**

Dosage and Method.....

Times of Administration.....

Any special precautions.....

.....

.....

Any possible side effects.....

Is supervised self-administration possible?.....

Pain/Flu Relief

- f. We will take **Calpol** (Six Plus Sugar-Free Paracetamol) and **Nurofen** (For Children 7-12 years Ibuprofen) with us on the trip. Please specify which of these pain/flu relief medications your child may be given if necessary.

If you would prefer to provide your own pain/flu relief medication, please use the space below to give details of the medication to be administered, including name, dosage and method.

.....

.....

.....

- g. Is your son/daughter allergic to any medication? YES/NO

If YES, please specify

.....

.....

- h. When was the last time your child received a tetanus injection?

.....

- i. Please use the space below to give us any other information you think necessary

.....

.....

.....

.....

Declaration

I agree to my son / daughter receiving medication as instructed above and any urgent dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

I will inform the School office/Group Leader/Head Teacher as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.

Signed: **Date:**

Full name (capitals):

Relationship to child.....

Contact telephone numbers:

I may be contacted by telephoning the following numbers:

Work: Home:.....

Home address:

.....

If I am not available at above, please contact:

Name:..... Tel No:.....

Relationship to child:.....

Address:

.....

THIS FORM OR THE INFORMATION IT CONTAINS WILL BE TAKEN BY THE GROUP LEADER ON THE VISIT. DUPLICATE INFORMATION WILL BE RETAINED BY THE SCHOOL CONTACT.