

**PARENT/CARER CONSENT FOR AN EDUCATIONAL VISIT – Sheffield LA**

**1. Details of visit to:**

From (date/time): \_\_\_\_\_ To (date/time): \_\_\_\_\_

I agree to \_\_\_\_\_ (name)

taking part in this visit and have read and understand the information provided. Yes

I acknowledge the need for my son/daughter to behave responsibly. Yes

I agree to my son/daughter's participation in the activities described (with the exception of those indicated below). Yes

Are there any activities which your child cannot participate in? Yes  No   
 If yes, provide details here:

Is your child entitled to Free School Meals? Yes  No

**2. Medical information about your child**

a) Date of birth of your son/daughter: \_\_\_\_\_

b) Does your child suffer from any conditions which the visit leader needs to be aware of for example: medical conditions, illness, allergies, night-time tendencies (sleepwalking, bedwetting, nightmares), travel sickness etc? Yes  No

c) If yes, please provide details:

d) Does your child take medication? Yes  No

e) If Yes, please give details, including how medication is administered, including details of medication, timing, dosage and any side effects:

f) Please outline any special dietary requirements of your child:

i) Is your son/daughter allergic to any medication? Yes  No   
 j) If Yes, please specify:

l) I will inform the visit leader/Principal as soon as possible of any changes in medical or other circumstances between now and the commencement of the visit.

Yes

m) I agree to my son/daughter 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.

Yes  No

### 3. Contact information

I can be contacted using the following telephone numbers: ***Please ensure any changes to these details are notified to the academy prior to the trip.***

Work: \_\_\_\_\_ Home: \_\_\_\_\_

Home address: \_\_\_\_\_

Alternative contact (name): \_\_\_\_\_ Telephone number: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to pupil: \_\_\_\_\_

Name of family doctor: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Address: \_\_\_\_\_

### 4. I consent to my child taking part in this visit:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Full name (capitals): \_\_\_\_\_

**Information contained in this form should be readily available to the leader throughout the visit. This means taking a copy of the completed form(s) on the visit. Copies should also be retained by the academy and emergency contacts.**