

LEV 3 (Jan 2012 Vers)

PARENTAL CONSENT FORM FOR A SCHOOL VISIT

NATURE OF VISIT: GCSE PE TRIP (INDOOR CLIMBING & ROAD CYCLING)

1. **Details of visit to: HIGH ADVENTURE OUTDOOR EDUCATION CENTRE, 233 KEIGHLEY ROAD, COWLING, KEIGHLEY, WEST YORKSHIRE BD22 0AA, 01535 630044**

From: Friday 13th March 2020, 6.00AM

To: Monday 16th March 2020, 7.00PM

I agree to _____ (name of child), taking part in this visit and have read the information letters. I agree to my child's participation in the activities described. I acknowledge the need for him/her to behave responsibly.

2. Medical information about your child

- a. Any condition requiring medical treatment, including medication? YES/NO
If YES, please give brief details: _____

- b. Please outline any allergies or special dietary requirements of your child (not preferences).

- c. Details of any medication currently being taken or likely to be needed:

For residential visits and exchanges only

- c. 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 contagious or infectious? YES NO

If YES, please give brief details:

- d. Is your son/daughter allergic to any medication? YES NO
If YES, please specify:

e. When did your son/daughter last have a tetanus injection?

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

2. Declaration

I agree to my son/daughter receiving medication as instructed or 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 limitation of the insurance cover provided. I have also read and understand the pre-trip letter that includes emergency contact information, an itinerary and a kit list.

Contact telephone numbers:

Work: _____ Home: _____

Home address: _____

Alternative emergency contact:

Name: _____ Telephone number: _____

Address: _____

Name of family doctor: _____ Telephone number: _____

Address: _____

Signed: _____ Date: _____

Full name (capitals): _____