



# Activity Parental Consent Form & Indemnity

Please ensure that this form is complete and contains all of the relevant information about the young person. Staff rely on this form for information, especially when they are running a visit outside of school hours (no office support).

<b>Legal Name of young person:</b>		<b>Tutor Group</b>	<b>Date of birth:</b>	
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## Main contact details

<b>Young person's home address:</b>				<b>Postcode:</b>
<b>Name of parent/legal guardian:</b>				
<b>Home telephone no:</b>			<b>Mobile no:</b>	
<b>Contact email address:</b>				

## Visit Information

<b>Visit to :</b> _____
<b>Date from (time &amp; date)</b> _____ <b>Date To (time &amp; date)</b> _____

## Personal information

**Does the young person have a care plan?** YES/NO (delete as appropriate)

**ANY MEDICAL CONDITIONS REQUIRING MEDICAL TREATMENT?** Please give details in the box below about any medical conditions, including type of medicine, and size and frequency of dosage. All medicines **must** be clearly labelled with your child's name and clear instructions of use. **Please note that they cannot be administered if not listed on this form and medicine must be handed in to the appropriate member of staff.**

<b>Condition :</b>		<b>Condition :</b>	
<b>Name of Medicine :</b>		<b>Name of Medicine :</b>	
<b>Dosage to be given :</b>		<b>Dosage to be given :</b>	
<b>Times to be given (if as and when, please put this) :</b>		<b>Times to be given (if as and when, please put this) :</b>	
<b>Any known side effects :</b>		<b>Any known side effects :</b>	

**ALLERGY TO MEDICATION:** Please give details of any MEDICINE to which they have an allergy (e.g. penicillin).

**ALLERGIES/SPECIAL DIETARY NEEDS:** Please indicate any specific **FOODSTUFFS** to which they have an allergy (e.g. NUTS), or if they have a special dietary need (e.g. Vegetarian).

**INJECTIONS:** Please give the date of their last tetanus injection.

**OUTLINE THE PAIN/FLU RELIEF MEDICATION THEY MAY BE GIVEN IF NECESSARY:**

**ANY SPECIFIC/RELEVANT LEARNING DIFFICULTIES:** Please give details of any relevant conditions that may affect the activity (e.g. Dyslexia).

**OTHER DETAILS:** Is there anything else we need to know which is not covered in any of the other sections?

<b>Name of family doctor:</b>	<b>Telephone no:</b>
<b>Address:</b>	

**Water confidence** (complete if appropriate)

Is the young person named on this form:

- ABLE TO SWIM 50 METRES?** YES/NO (delete as appropriate)
- CONFIDENT IN A SWIMMING POOL?** YES/NO (delete as appropriate)
- SAFETY CONSCIOUS IN WATER?** YES/NO (delete as appropriate)
- CONFIDENT IN OPEN INLAND WATER?** YES/NO (delete as appropriate)
- CONFIDENT IN SEA CONDITIONS?** YES/NO (delete as appropriate)

**Alternative contact for emergencies**

This section must be completed and different from the main contact:

<b>Name of alternative contact:</b>	
<b>Relationship to young person:</b>	
<b>Home telephone no:</b>	<b>Mobile no:</b>
<b>Address:</b>	

**Declaration** (important small print to read)

I agree to \_\_\_\_\_(name) attending \_\_\_\_\_ and to take part in associated activities. I have read the information letter and understand the nature of the activities that my son/daughter will be taking part in. I acknowledge the need for responsible behaviour, and understand that if my son/daughter has to be removed from any activity I will meet any costs incurred.

I will inform the Group Leader of any changes in the medical or contact details before the trip.

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.

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

<b>SIGNED:</b>	<b>PRINT NAME:</b>	<b>DATE:</b>
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