THE BUCKINGHAM SCHOOL
A SPECIALIST SPORTS COLLEGE

London Road
Buckingham
MK18 1AT
Tel: 01280 812206
Fax: 01280 822525
Email: office@buckingham.bucks.sch.uk
Website: www.buckinghamschool.com

Headteacher: Angela Wells

PARENTAL CONSENT FORM – HAZARDOUS / RESIDENTIAL / OVERSEAS VISIT **EV9**

DETAILS OF VISIT: (PLEASE COMPLETE ALL DETAILS IN EACH BOX)

Visit to: _____ **Subject:** _____

From (Date/Time): _____ **To (Date/Time):** _____

I agree to my child (name) _____ **taking part in the abovementioned visit and having read the information sheet, agree to his/her participation in the activities described. I fully support the School Code of Conduct for Trips and Visits.**

MEDICAL INFORMATION ABOUT YOUR CHILD

a) Does your son/daughter suffer from any condition requiring medical treatment or medication?
If YES, please list: **YES / NO**

_____

b) 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 or become contagious or infectious?
If YES, please list: **YES / NO**

_____

c) Is your son/daughter allergic to any medication or treatment?
If YES, please list: **YES / NO**

_____

d) Has your son/daughter received a tetanus injection in the last five years? **YES / NO**

e) Does your child have any special dietary requirements? **YES / NO**

CONSENT TO TAKE PHOTOGRAPHS DURING THE TRIP:

I consent that at some point during this trip a photograph including my child will be taken to be used for public relations by the school, i.e.; School Bulletin; School website etc.

Signed (Parent/Carer): **Date:**

DECLARATION:

To the best of my knowledge my child is not suffering from any medical condition that makes him/her unfit to participate in this visit or the activities described. I agree to my son/daughter receiving medical treatment as instructed and any urgent dental, medical or surgical treatment, including anaesthetic and blood transfusion, as considered necessary by the medical authorities present. I understand the extent and limitations of the insurance cover provided.

Signed (Parent/Carer): _____ **Date:** _____

Name of Parent/Carer:

PARENTAL CONSENT FOR SCHOOL TO ADMINISTER MEDICINE – PRESCRIPTION OR OCCASIONAL NON-PRESCRIPTION MEDICINE: **EV9**

The school will not give your child medicine unless you complete and sign this form, and the school has a policy that staff can administer medicine. Medicines must be in the original container which must contain the Patient Information Leaflet.

Name of child: _____ DOB: _____

Medical Condition: _____

Name / type of medicine (as described on the container): _____

Date dispensed: _____ Expiry date: _____

Agreed review date to be initiated by member of staff (name): _____

Dosage and method: _____ Timing: _____

Special Precautions: _____

Are there any side effects that the school needs to know about? _____

Self administration: YES_____ NO _____ Procedures to take in an Emergency: _____

I may be contacted by telephoning the following numbers:

Mobile: _____ **Work**: _____ **Home**: _____

My home address is:

_____

In case I cannot be contacted on the above, please contact:

Name: _____ Relationship to Student: _____

Address: _____

Mobile: _____ **Work**: _____ **Home**: _____

Name, address and telephone number of family doctor: _____

_____Telephone No: _____

I understand that I must deliver the medicine personally to the Trip Leader / First Aid Officer and accept that this is a service the school is not obliged to undertake.

(Non-prescribed medicine): I confirm that I have administered this non-prescription medication without adverse effect to my child in the past. I will inform the school immediately, in writing, if my child is adversely affected by the above medication.

I undertake to inform the Party Leader / Headteacher in writing as soon as possible of any change in the medical circumstances between the date signed and the commencement of the visit.

Signed (Parent/Carer): _____**Date:** _____

FULL NAME: _____