

PARENT / CARER CONSENT FOR AN EDUCATIONAL VISIT

This form must be distributed with an information sheet giving full details of the visit.

Name of pupil: _____ Male ☐ Female ☐

Primary School: _____ Age whilst on visit:

Visit to: **Year 6 Out of Zone Transition Visit to;**

The Conway Centre - Anglesey, Llanfairpwllgwyngyll, Anglesey, LL61 6DJ

1. Permission (please tick)

☐ I have read the information sheet and I agree to my child's participation in this visit and in the activities described.

☐ I acknowledge the need for my child to behave responsibly throughout the visit.

2. Medical information about your child

a) Does your child have any conditions requiring medical treatment, including medication? **YES / NO**

If yes, please give brief details:

b) Please outline any food or other allergies and special dietary requirements of your child:

c) Has your child had any recent illness or accident staff should be aware of? **YES / NO**

If yes, please give brief details:

d) What type of pain/flu relief medication may your child be given if necessary?

3. For residential visits and exchanges only

a) Has your child been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be contagious or infections? **YES / NO**

If yes, please give brief details:

b) Is your child allergic to any medication? **YES / NO**

If yes, please specify

c) When did your son/daughter last have a tetanus injection?

4. Emergency Contact Details

a) Primary Emergency Contact Name: _____ Relation To Child: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Home Address: _____

Email Address: _____

b) Secondary Emergency Contact Name: _____ Relation To Child: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Home Address: _____

Email Address: _____

c) Name Of Family Doctor: _____ Telephone Number: _____

Address: _____

As part of the activities your son/daughter/ward are involved in photographs or video footage may be taken to be used in printed publications or publicity or promotional material including the local press.

Can we use the young person's photograph in this way?

YES / NO

Declaration

I agree to my son/daughter/ward 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.

Signed: _____ Date: / /

Relation To Child: _____

Full Name (please print clearly): _____

THIS FORM OR A COPY WILL BE TAKEN BY THE LEADER OF THE VISIT.

A COPY MUST BE RETAINED BY THE ESTABLISHMENT CONTACT