KING JAMES'S SCHOOL, KNARESBOROUGH

PARENTAL CONSENT FOR A ROLLING PROGRAMME OR SERIES OF LOCAL VISITS

INFORMATION FOR PARENTS/GUARDIANS

Please complete the questions below and sign the consent. This form should be completed annually (one copy will be held by school and Out of Hours contact. One copy to be taken by group leader on visit). If a request is made subsequently for the withdrawal of the form, a note or letter to that effect will be placed on the file and the copy of the form will be crossed through stating that the form has been withdrawn and the date on which such withdrawal takes effect.

Academic Year:	**2013/14**

PUPIL DETAILS			
Student Name:		Tutor Group:	

I understand that my child may leave the school premises for local visits and hereby give my consent for my child to participate in such visits.

I also understand that should my child need to leave the school premises at other times, I will be informed separately by letter and further parental consent will be sought.

I undertake to inform the Group Leader/Headteacher in writing as soon as possible of any change in the student's medical or other circumstances which may occur after the date shown below.

PARENT/ CARER	**Name:** (PLEASE PRINT)	
	Signed:	
	Date:	

EMERGENCY CONTACT INFORMATION

I may be contacted by telephoning the following numbers:

		Please annotate tel nos in call order (eg. 1,2,3)
Work Tel:		
Home Tel:		
Mobile Tel:		
Home Address:		

If you are not able to contact me, please contact:

Name: (PLEASE PRINT)		**Please annotate tel nos in call order (eg. 1,2,3)**
Work Tel:		
Home Tel:		
Mobile Tel:		
Home Address:		

MEDICAL INFORMATION

If your son/daughter has a medical condition of any sort, please discuss it with your family doctor before completing the form. Medical conditions would not normally exclude your son/daughter from participating in activities. It is important that your son/daughter is accompanied by any medication necessary and that we are made aware of this. Please make sure that they have enough medication with them.		Please ✓ as appropriate	
		Yes	**No**
Has your son/daughter had any serious illness in the last 2 months?			
Is your son/daughter recovering from an accident, injury or fractured bone?			
Does your son/daughter have:	**Epilepsy or convulsions**		
	Diabetes mellitus		
	Asthma		
	Heart Disease		
	Any allergies		
Is your son/daughter on any medication? (If Yes, give details below)			

If the answer to any of the above questions is **Yes**, please give details here (detailing dosage and frequency of any medication)

Do you consider your son/daughter to be medically fit now?	❑ Yes ❑ No	If NO, give details here	
Has your son/daughter been inoculated against TETANUS?✓	❑ Yes ❑ No	**Date of last injection if known**	

MEDICAL TREATMENT DURING VISITS

Young people sometimes need minor medical treatment for conditions such as headaches, rashes, pulled muscles, coughs & colds, insect bites, etc. With your permission, the Centre staff will treat these ailments with "off the shelf" products from a chemist. For example, the following items are available: paracetemol, muscle relaxant cream/spray, witch hazel, throat lozenges, petroleum jelly, cough mixture, antiseptic cream, calamine lotion, adhesive plasters, insect bite antihistamine.	Please ✓ as appropriate	
	Yes	**No**
Are you willing for your son/daughter to be treated with "off the shelf" medication? Professional help would be sought for any more serious conditions and we will contact you by telephone.		
Are you willing for your son/daughter to undergo emergency treatment from a doctor or hospital should this be necessary?		

Consents for procedures to take in an emergency ✓ as appropriate	❑ I give my consent ❑ I do not give my consent For a member of staff to administer the above medication which I will deliver to the Group Leader before the visit, together with clear labels and instructions. I understand that the staff leading the visit are not qualified medical practitioners but that they will take reasonable care in the administration of the medication and will endeavour to respond appropriately should emergency treatment be required.
	❑ I give my consent ❑ I do not give my consent For my son/daughter to self-administer the above medication.

DIETARY INFORMATION

Does your son/daughter have any individual dietary needs (including vegetarian foods)? Please give details:

PHOTOGRAPHS

Photographs are often taken on school trips for use within school and for event reports on the school website, Chaloner magazine, etc.

I give consent for the use of photographs from rolling programme/local visit trip which include my child for the reasons detailed above (✓ as appropriate)	❑ Yes ❑ No