Parental Consent

1. Parish/Partnership

Name of Parish	
Name of Partnership	

2. Session Dates Times and Venues

As on Programme

I agree to	(Insert name)
Date of birth	
Age	
Name of School	
Home Address	
Mobile number of young person	
Email address of young person	
Mobile number of Parent/Guardian	
Email address of Parent/Guardian	
Signature of Parent/Guardian	
Name of Parent/Guardian	(Please print)
Date signed	

3. Transport Arrangements

(For which parents/guardians hold responsibility)

Please detail how your son/daughter will travel to and from the sessions for the residential trip.	

4. Medical Information

A) Does your child have any condition/s requiring medical treatment including medication e.g. inhalers, anti-epileptics or insulin?

☐ Yes	Please give details below
☐ No	

B) Please outline any special dietary requirements of your child (including allergies e.g. nuts) and the type of pain/flu relief medication your child may be given if necessary.

C) Please outline any FEARS OR PHOBIAS your child has.
(This information will assist the adult helpers to assist your child should any difficulties arise)

D) Is your son/daughter allergic to any medication e.g. penicillin?

☐ Yes	Please give details below
☐ No	

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

F) Is there any other relevant information/specific requirement/s that need to be known by the organiser? e.g. travel sickness/mobility

G) FOR RESIDENTIAL TRIPS ONLY - 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 few weeks that may be contagious?

☐ Yes	Please give details below
☐ No	

Please inform the event leader as soon as possible of any changes in the medical or other circumstances between now and the end of the programme.

4. Parental Contact Information

Name	
Mobile Number	
Work Telephone Number	
Home Telephone Number	
Home Address	
Alternative Emergency Contact	
Name	
Telephone Number	
Name of Family Doctor	
Doctor’s Telephone Number	
Doctor’s Address	

5. Declaration

In the event of an illness or accident every effort will be made by the event leader or their assistants to contact me. If for whatever reason this is not possible, 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.

Signature	
Full Name (BLOCK LETTERS)	