# OFF-SITE VISIT PARENTAL CONSENT FORM
# CONFIDENTIAL INFORMATION

Information given on this form will not prejudice the inclusion of your child on the trip.
It is essential to complete this form accurately in the interests of your child's safety.

Pupil's surname | Pupil's forenames

School: The Bulwell Academy | Class | Age on departure years | months

Visit to: Walesby Forest | From | Until

I wish my son/daughter to take part in the above mentioned visit and having read the information sheet, agree to him/her taking part in the activities described. I have discussed the information sheet with my son/daughter who understands the requirements which have to be observed.

I shall instruct my child to wear a seat-belt whist travelling by motor vehicle and to abide by any other safety instructions and behavioural requirements.

Signed _____

*Father - Mother - Legal Guardian.*

To ensure that parents may be contacted if necessary - please complete the following:

| Parents name and home address | Telephone numbers | |
|---|---|---|
| | Home | |
| | Work | |
| | Mobile | |

| Parent's address if different during the visit | Telephone numbers | |
|---|---|---|
| | Home | |
| | Work | |
| | Mobile | |

| Second contact - neighbour/friend's name and address | Telephone numbers | |
|---|---|---|
| | Home | |
| | Work | |
| | Mobile | |

Can your child swim 50 metres? YES ☐ NO ☐

Does your child follow a special diet?

Does your child have any condition requiring medical treatment, including medication? Please give details:

Immunisation status

Is your child vaccinated against Tetanus YES ☐ NO ☐

Date of injection booster

Please give details of any other relevant vaccinations:

If your child has recently been exposed to any infectious diseases he/she should be examined by a doctor and a letter of fitness to participate must be issued.

Has your child suffered from any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Asthma or Bronchitis | YES ☐ | NO ☐ | | Recent Fracture or Ligament Damage | YES ☐ | NO ☐ | |
| Heart condition | YES ☐ | NO ☐ | | Fits, Feinting or Blackouts | YES ☐ | NO ☐ | |
| Severe Headaches or Migraine | YES ☐ | NO ☐ | | Diabetes | YES ☐ | NO ☐ | |
| Haemophilia | YES ☐ | NO ☐ | | Sleep walking | YES ☐ | NO ☐ | |
| Any Allergies | YES ☐ | NO ☐ | | Any other illness or disability (Please attach details) | YES ☐ | NO ☐ | |

Please give your family doctor's Name, Address and Telephone Number.

Name

Address

Telephone Number

If the trip is due to return after School hours please indicate if you will be collecting your child YES ☐ NO ☐

If not, how will they be getting home?