St Peter & St Paul
Catholic Voluntary Academy
Pro Petro Paulo Patria

PARENTAL/MEDICAL CONSENT

FOR

NAME OF TRIP: ……

Name of Pupil: ..... Year Group: .....

I/we agree to my/our son/daughter taking part in the above visit. I/We agree to his/her participation in any or all of the activities subject to them being properly risk assessed. I/We acknowledge the need for obedience and responsible behaviour on his/her part.

MEDICAL

Please list any medical conditions your child has that may require medical treatment and list any medication they may need:

.....

.....

Is your child allergic to any medication?

.....

.....

In the event of a minor ailment what, if any, medication can we give your child and in what dosage?

.....

.....

DIETARY

Does your child have any special dietary requirements?

.....

.....

Is your child allergic to any food groups?

.....

DECLARATION

I agree to my child receiving medical treatment, including anaesthetic, as considered necessary by the medical authorities present. I am aware of the extents and limitations of the insurance cover provided and understand that I can take out added insurance cover should I so wish.

CONTACT DETAILS

I may be contacted by phoning the following numbers:

Home:**.....**

Work:**.....**

Mobile:**.....**

My Home Address is:

.....

.....

.....

If I am unavailable please contact:

Priority	**Name**	**Phone**	**Relationship**
.....	**.....**	**.....**	**.....**
.....	**.....**	**.....**	**.....**
.....	**.....**	**.....**	**.....**

FAMILY DOCTOR .....

ADDRESS: .....

.....

..... PHONE: .....

SIGNED: ..... NAME IN CAPITALS:.....

RELATIONSHIP TO PUPIL: ..... DATE: .....