



PARENTAL CONSENT FOR A SCHOOL VISIT SWR 40th Anniversary Celebration Trip 2016 - Year 8

School/Group: Sir William Ramsay School, Rose Avenue, Hazlemere, Bucks, HP15 7UB

Pupil's name: Date of birth

Visit to: Science Museum, London
From: Monday 11 July 09:00hrs To: Monday 11 July 15:00hrs

1. I agree to my son / daughter taking part in this visit and have read the information sheet. I agree to his / her participation in the activities described. I acknowledge the need for and expect him / her to behave responsibly.

2. Medical information about your child

a. Any conditions requiring medical treatment, including medication? YES/NO
If YES, please give brief details:

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.....
.....

Please outline any special dietary requirements of your child and the type of pain/flu relief medication your child may be given if necessary:

b.
.....
.....

c. 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 four weeks that may be contagious or infectious?

YES/NO

.....
.....

d. Is your son/daughter allergic to any medication? YES/NO
If YES, please specify

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.....

e. When was the last time your child received a tetanus injection?

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Declaration

I agree to my son / daughter receiving medication as instructed and any urgent 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. (See details on the school website.)

I will inform the Group Leader/Head Teacher as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.

Signed: **Date:**

Full name (capitals):

Contact telephone numbers:

I may be contacted by telephoning the following numbers:

Work: Home:.....

Home address:

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Email address 1:

Email address 2:

If I am not available at above, please contact:

Name:..... Tel No:.....

Address:

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Name and address of family doctor:

Name: Tel No:

Address:

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THIS FORM OR A COPY WILL BE TAKEN BY THE GROUP LEADER ON THE VISIT. A COPY WILL BE RETAINED BY THE SCHOOL CONTACT