



PARENTAL CONSENT FOR A SCHOOL VISIT Spanish and Art Trip 2016

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

Pupil's name: Date of birth

Visit to: **Barcelona, Spain**

From: **Friday, 21 October 2016**

To: **Tuesday, 25 October 2016**

1. I agree to (name) taking part in this visit and have read the information sheet. I agree to’s participation in the activities described. I acknowledge the need for 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:

.....
.....

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

.....
.....

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

.....
.....

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

.....

Head: Mark Mayne

Rose Avenue, Hazlemere, High Wycombe, Bucks HP15 7UB T: 01494 815211 E: office@swr.bucks.sch.uk www.swr.bucks.sch.uk



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.

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:.....

Mobile: Other:.....

Home address:
.....

E-mail:

If I am not available at above, please contact:

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

Address:
.....

Name and address of family doctor:

Name: Tel No:

Address:
.....

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