**ANNUAL CONSENT FOR LOCAL OFF-SITE VISITS AND**

**MEDICAL TREATMENT**

Name of Child/Young Person…………………………………………………………..Date of Birth………………………….

I understand that my child may leave the school premises for local visits and hereby give my consent for my child to participate in such visits. I also understand that my child may leave the school premises at other times when I will be informed separately by letter and when further consent will be required from me.

I agree to my child receiving medication as instructed and any urgent medical, dental or surgical treatment of any nature, 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 agree that if my child urgently requires medical, surgical or dental treatment and it is not possible to contact me/us, the visit leader in charge at the time is authorised on my/our behalf to give consent to such emergency treatment.

I undertake to inform the visit leader/headteacher as soon as possible of any change in the medical or other circumstances after the date shown below.

I understand that my child may be videoed or photographed to promote off-site activity at the school. I give consent for video and photographs to be taken of my child. I also understand these might be used for promotional purposes including online and on social media. **YES/NO**

Signed …………………………………………………………….Name…………………………………………………………………………….

*(Parent/Carer)*

Date………………………………………………………………

Signed ……………………………………………………………..Name……………………………………………………………………………

*(Parent/Carer)*

Date……………………………………………………………..

I/We may be contacted by telephoning the following numbers:

Home…………………………………..Work……………………………………………Mobile………………………………………………

Home Address……………………………………………………………………………………………………………………………………

If the above contact is unavailable then please contact:

Name……………………………………………………………………………………………………………………………………………………

Home…………………………………………..Work……………………………………………Mobile……………………………………..

Home Address……………………………………………………………………………………………………………………………………..

Name, Address and telephone number of family doctor………………….……………………………………………....

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Does your child suffer from any conditions requiring medical treatment or medication? **YES/NO**

Is your child allergic to any medication or treatment? **YES/NO**

If so please give details:

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

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Please outline any special dietary requirements of your child:

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**This form should be completed annually/when a child is first admitted to school. It will be placed on the child’s school record and will be used throughout the compulsory schooling. If a request is made subsequently for the withdrawal of the form a note or letter to that effect will be placed on the file and the copy of the form will be crossed through stating that the form has been withdrawn and the date on which such withdrawal takes effect.**