Abbey Primary School
Stuart Avenue, Forest Town
NG19 0AB
Email: office@abbey.notts.sch.uk
☎: 01623 481117

Headteacher: Mr Neil Harris

RESIDENTIAL TRIP CONSENT FORM

Trip to: _____

Trip date: _____ Year group: _____

Child's full name: _____

Date of birth: _____ / _____ / _____ Gender _____

Home Address: _____

EMERGENCY CONTACT NAMES AND TEL. NOS.

Full Name	Telephone	Relationship to child
	Mobile: **Home:** **Work:**	
	Mobile: **Home:** **Work:**	
	Mobile: **Home:** **Work:**	

Doctor's name: _____

Doctor's surgery name and address: _____

Doctor's surgery telephone number: _____

CONSENT AND BEHAVIOUR

I give my consent for the above-named child to participate in the above residential trip, having read the provided information and agreeing to their involvement in any or all the activities outlined in the itinerary. I understand the importance of my child demonstrating responsible behaviour throughout the trip. If their behaviour does not meet expectations or if they pose a risk to themselves or others, I may be required to collect them.

Signed _____ Date _____

MEDICAL INFORMATION:

Does your child suffer from any medical conditions? YES/NO. If YES, please provide details.

_____

_____

_____

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Is your child currently taking any medication? YES/NO. If YES, please complete the table attached.

Does your child suffer from any food intolerances/allergies? YES/NO. If YES, please provide details.

_____

_____

Does your child suffer from any other allergies? YES/NO. If YES, please provide details.

_____

_____

Is your child allergic to any medication, e.g. penicillin? YES/NO. If YES, please provide details.

_____

_____

Does your child have any other special needs we should know about, e.g. sleepwalking/bedwetting? YES/NO. If YES, please provide details.

_____

_____

_____

_____

CALPOL ADMINISTRATION CONSENT

I give consent for the administration of Calpol (as per the dosage stated on the bottle) to my child during the above residential visit, if medically required. ***(You are not obliged to sign this declaration)***

Signed _____ **Date** _____

EMERGENCY MEDICAL TREATMENT

I _____ being the parent/guardian of _____ delegate responsibility for authorising serious emergency medical treatment to the adult(s) in charge of his/her school party. I understand that every effort would be made to contact me before such treatment was authorised.

Signed _____ **Date** _____

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MEDICATION TO BE ADMINISTERED WHILE ON RESIDENTIAL

Child's Name: _____ Class: _____

The school will not give your child medicine unless you complete and sign this section of this form.

Medical Condition	Name of Medication	Do we administer this in school already? Y/N	Dosage	Times to administer Date – time / As and when needed.	Expiry Date	Self-Administration Yes/No	Received

- ☐ **I understand that I must deliver all medicines personally to a member of staff on the morning of the residential unless it is already in school.**
- ☐ **The medication will be clearly labelled with my child's name. Please ensure the medication is within its use-by-date.**

Signed: _____ Date: _____

Printed Name: _____ Relationship to Child: _____