

Participant Consent Form

For Category 2/Adventurous & Residential Visits

Visit Details

| | | | | |
|---------------------|---|---------------|----------------|--------------|
| Visit Name: | Ford Castle Residential 2025 | Dates: | From: 04.06.25 | To: 06.06.25 |
| Planned Activities: | Year 4 Residential Trip to Ford Castle 2025 | | | |

Participant Details

| | | | |
|------------------------------------|--|--|--|
| Name of child: | | Class/Group: | |
| Address: | | | |
| Sex: <i>(as birth certificate)</i> | | Gender identity: <i>(if differs to certificate)</i> | |

Details of parent (or person with parental responsibility) completing this form

| | | | |
|---|--|-----------------------------------|--|
| Your name: | | Your relationship to participant: | |
| Your Address: <i>(if different from participant)</i> | | | |
| Your phone numbers: | | | |
| Your email: | | | |

Details of any other parent (or person with parental responsibility)

| | | | |
|----------------------------------|----------------------------------|------------------------------|--|
| Name: | | Relationship to participant: | |
| Address, phone number and email: | <i>(if different from yours)</i> | | |

Emergency contact details:

(Please provide details of any other person who can be contacted in an emergency if you or the other parent above might not be available)

| | | | |
|----------------|--|------------------------------|--|
| Name: | | Relationship to participant: | |
| Phone numbers: | | | |

Health, Welfare & Medical Information:

For the child's safety and welfare, it is vital that you provide full and accurate information to all the following questions about them.

Does the child have any allergies (such as to particular foods, medication, or other factors such as bee stings)? If so, please provide details.

Does the child have any medical conditions, mental health conditions, impairments, or disabilities?

Has the child had any recent significant medical treatment, illness, infectious disease or injury? If so, please provide details.

When did the child last receive a tetanus injection? DD | MM | YY

Does the child have any dietary requirements – for example, is there any food that they should not eat? If so, please provide details.

Does the child have any other conditions or needs (for example: mobility needs, communication issues, behavioural issues, travel sickness, toileting issues)? If so, please provide details.

Does the child have any night-time tendencies such as sleepwalking, nightmares or bedwetting which might affect them during a residential visit? If so, please provide details.

As far as you know, are there any reasons which mean the child is not fit to participate in any of the planned activities? If so, please provide details.

Will the child need to take any medication during the visit? If so, please provide the following details:

| Name of medication | Dosage | When to be taken | Method of administration |
|--------------------|--------|------------------|--------------------------|
| | | | |

Does the child have an asthma inhaler or adrenaline auto-injector? If so, please provide details and state whether they are able to carry and use it themselves or whether a member of staff will need to take responsibility for it.

To the best of your knowledge, has your child been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be, or become, contagious or infectious?
Yes **No** **N/A**
If yes, give brief details:

Is your child allergic to any medication?
Yes **No** **N/A**
If yes, give brief details:

| | | | |
|-----------------------|--|------------------|--|
| Family Doctor: | | Contact Number: | |
| Surgery Name: | | Surgery Address: | |

| Declaration | | | |
|--|---|---|---|
| <p>Information</p> <p>In signing this form I confirm that I have fully and correctly provided all information requested by this form, and that I will inform the establishment as soon as possible should any of the facts change.</p> <p>I give my consent for this information to be shared with visit staff and any providers or other parties, as is necessary for the health, safety and welfare of my child, under the terms of the establishment's Privacy Policy.</p> | | | |
| <p>Medication</p> <p>I will deliver the medication which I have listed above to the Visit Leader before the visit, clearly labelled in its original packaging together with official instructions and information.</p> <p>I understand that the staff leading the visit are not qualified medical practitioners, but that they will take reasonable care in the administration of the medication.</p> <p>Please delete which of the following does not apply:</p> <p style="padding-left: 40px;">I give my consent for a member of staff to administer the medication listed above.</p> <p style="padding-left: 40px;">I give my consent for my child to self-administer the above medication, under the supervision of a member of staff.</p> <p>My child has been prescribed an asthma inhaler. In the event of an asthma attack, if their inhaler is not available or is unusable, I consent for them to receive salbutamol from an emergency inhaler if one is available.</p> | | | |
| <p>Treatment for minor ailments</p> <p><i>Participants occasionally need first aid or medical treatment during a visit for minor ailments such as sunburn, heat rash, insect bites, period pains, headaches, athlete's foot, indigestion, sore throats, coughs, cuts and grazes. When necessary, and with your consent, staff will provide prevention or treatment of these ailments with the non-prescription products which are commonly available at pharmacies. If more than one dose of pain relief medication (such as paracetamol) is required, you will be contacted for further consent.</i></p> <p>I give my consent for a member of staff to administer the following common non-prescription products for minor ailments <i>[please delete any that you do not want administered]</i>. I understand that the staff leading the visit are not qualified medical practitioners, but that they will take reasonable care in the administration of the medication and will follow the products' instructions regarding dosage and children's ages.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <i>Suncream</i> <i>After-sun lotion</i> <i>Insect repellent</i> <i>Calamine lotion</i> <i>Antihistamine cream</i> </td> <td style="width: 33%; vertical-align: top;"> <i>Paracetamol (Calpol etc.)</i> <i>Athlete's foot cream</i> <i>Antacid tablets</i> <i>Throat lozenges</i> </td> <td style="width: 33%; vertical-align: top;"> <i>Cough syrup</i> <i>Antiseptic cream</i> <i>Antiseptic wipes</i> <i>Hypoallergenic adhesive plasters</i> </td> </tr> </table> | <i>Suncream</i> <i>After-sun lotion</i> <i>Insect repellent</i> <i>Calamine lotion</i> <i>Antihistamine cream</i> | <i>Paracetamol (Calpol etc.)</i> <i>Athlete's foot cream</i> <i>Antacid tablets</i> <i>Throat lozenges</i> | <i>Cough syrup</i> <i>Antiseptic cream</i> <i>Antiseptic wipes</i> <i>Hypoallergenic adhesive plasters</i> |
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| <p>Emergency medical treatment</p> <p>In the event of a medical emergency, I consent to my child receiving emergency medical or dental treatment, including anaesthetic or blood transfusion, if it is considered necessary by the medical authorities present.</p> | | | |
| <p>Property</p> <p>I understand that my child is responsible for looking after their own property during the visit, and that the establishment is not liable for any loss or damage to it.</p> | | | |

Signature

Note: for any overseas visit, this form must be signed by all those with parental responsibility for the participant

Name:

Relationship to participant:

Signature:

Date:

Name:

Relationship to participant:

Signature:

Date:

Any other relevant information:

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