

## Lledr Hall OEC

### Overnight stay Parent / guardian consent form

School/group \_\_\_\_\_ visit to **Lledr Hall OEC**  
from \_\_\_\_\_ to \_\_\_\_\_ (dates inclusive)

I agree to my son/daughter \_\_\_\_\_ date of birth \_\_\_\_\_

taking part in this visit and agree to his/her participation in the activities described.  
I acknowledge the need for responsible behaviour on his/her part.

### Medical information

If your son/daughter suffers from any conditions requiring medical treatment, including medication, please give details.

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If your son/daughter has been in contact with, or suffered from any contagious or infectious diseases in the last four weeks, please give details.

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If your son/daughter has any allergies, including medication, please give details.

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Please provide any other relevant medical, behavioural, social or dietary information not mentioned above.

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Has your son/daughter had a tetanus injection in the last five years?

YES / NO

Name of family doctor: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone number: \_\_\_\_\_

### Photographs

Lledr Hall occasionally uses photographs in promotional information. If you have any objection to your child's photograph being used for this purpose, please tick the box.

### Declaration

I agree to my son/daughter receiving medication as instructed and any emergency 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 confirm that my child is in good health and fit to participate in the activities described.

Signed: \_\_\_\_\_ Parent / guardian

Print name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home telephone: \_\_\_\_\_

Work telephone: \_\_\_\_\_

Date: \_\_\_\_\_

Alternative emergency contact.

Name: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

This form must be taken by the group leader on the visit. A copy should be retained by the school contact.