

OVERNIGHT STAY PARENT / GUARDIAN CONSENT FORM

I am willing to allow my son / daughter _____

DATE OF BIRTH _____

to attend _____

from _____ to _____

I am willing to allow him / her to take part in the full programme of activities which has been arranged.

As far as I am aware he / she has not been in contact with any infectious disease for the last three weeks, and is in good health.

In the event of our son / daughter being taken ill or injured during the period of the visit to the extent that a surgical operation or serum injection becomes necessary, I authorize

_____ to sign on my behalf any forms of consent required by the hospital authorities, provided the delay required to obtain my own signature might be considered likely in the opinion of the doctor or surgeon concerned to endanger my son's / daughter's health or safety.

My son / daughter has / has not been actively immunised against tetanus.

He / she is / is not as far as I am aware, sensitive to penicillin.

I understand that during the period of the visit my son / daughter will be in your charge, through the leaders responsible for the period in question, and under your instructions.

I accept whatever disciplinary arrangements have been agreed for the period of the visit.

Signed: _____ Parent / Guardian

Address: _____

Tel N°: _____

In Emergency: _____

Date: _____

1. Does your child suffer from fainting attacks or blackouts? Yes / No
2. Does your child suffer from fits of epilepsy? Yes / No
3. Does your child suffer from any allergy, asthma or hay fever? Yes / No
4. Does your child suffer from diabetes? Yes / No
5. Does your child suffer from ear trouble? Yes / No
6. Does your child suffer from bed wetting? Yes / No
7. Does your child suffer from any illnesses not mentioned above?
If Yes - please give details: Yes / No

8. Are your child's teeth in good condition? Yes / No
If you are not sure, please get your dentist to
Check your child's teeth before the journey.

9. IS YOUR CHILD ON ANY SORT OF MEDICAL TREATMENT
AT THE PRESENT TIME? Yes / No
If Yes - please give details:

Name of medicine

How often taken

10. Please state the Name, Address and Telephone Number of your child's G.P.

Signed: _____

Date: _____