Telephone: 01928 788230 **Crowton Christ Church C of E**

Head Teacher: Miss. H. Bettley **Primary** **School**  e-mail:head@crowton.cheshire.sch.uk **Kingsley Road**

Website: www.crowton.cheshire.sch.uk/  **Crowton**

 **Cheshire**  **CW8 2RW**

 we **A**chieve, we **B**elieve, we **C**are

### PARENT / Guardian CONSENT FOR An educational VISIT

**Establishment/Group**: Class 4, Crowton Christ Church C of E Primary School

**Details of Visit to**: Round Ponds Adventure Centre, Kingsley Road, Frodsham, WA6 6SU

**From**: **Date**: 04.05.21 **Time**: 8:50am - Parents to drop child off with teacher at Kingsley Park (near Kingsley Community Centre)

**To:** **Date**: 04.05.21 **Time**: 3:15pm – Parents to collect child from Round Ponds

I agree to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) taking part in this visit.

I have read the information sheet I agree to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‘s participation in the activities described.

I acknowledge the need for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to behave responsibly throughout the visit.

**Medical information about your child**

a) Any conditions requiring medical treatment, including medication? YES/NO

If YES, please give brief details:

1. Please outline any food or other allergies and special dietary requirements of

your child:

1. Any recent illness or accident staff should be aware of?
2. The type of pain/flu relief medication your child may be given if necessary:

e) To the best of your knowledge, has your son/daughter been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be contagious or infections? YES/NO

If YES, please give brief details:

f) Is your son/daughter allergic to any medication? YES/NO

If YES, please specify:

g) When did your son/daughter last have a tetanus injection:

1.
2. **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.

**Contact telephone numbers**:

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work No**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home No**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email address**:

**Alternative emergency contact**:

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Tel No**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:

**Email address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of family doctor**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Telephone No**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:

**Signed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Full name (capitals)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As part of the activities your son/daughter/ward are involved in Cheshire West & Chester Council may take photographs or video footage to use in printed publications or publicity or promotional material including the local press.

**Can we use the young person’s photograph in this way**? YES / NO

**Signed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Full name (capitals)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIS FORM OR A COPY MUST BE TAKEN BY THE GROUP LEADER ON THE VISIT. A COPY SHOULD BE RETAINED BY THE ESTABLISHMENT CONTACT**