



Exmouth Community College

PARENTAL CONSENT FORM FOR OFF SITE ACTIVITIES

ALL ACTIVITIES REQUIRE THIS FORM TO BE COMPLETED

Dear Parent/Guardian

Please complete and return the form below. It relates to the forthcoming journey or activity for which you have already received details. This form gives your consent for your child to take part in this activity.

Please return this form with your payment to the Youth Office, the Grange, Gipsy Lane, Exmouth.

STUDENT NAME:	D.O.B:	TUTOR GROUP:
ADDRESS: POST CODE:	TELEPHONE NO: MOBILE NO: WORK:	
NAME OF ACTIVITY/S:	DATE OF VISIT/S:	
SPECIAL DETAILS: Any relevant information concerning your child's health requiring special attention but which does not prevent him or her taking part should be noted below: <i>[Please tick relevant box]</i>		
▪ Does your child suffer from any allergies? <i>If so, what are they:</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
▪ Does your child have any specific dietary requirements? <i>If so, what are they:</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
▪ Take medication and if so, what is the dosage required? <i>Dosage:</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
▪ Have diabetes, asthma or epilepsy?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
▪ Has your child had any relevant recent illness? <i>If so, what:</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
▪ Any additional information we should be aware of?		
▪ Date of last tetanus injection:		
SWIMMING ABILITY (for swimming activities)		
▪ Is your child able to swim 50 metres?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
▪ Is your child water confident?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

1. I would like my son/daughter to take part in the above mentioned visit or activity and having read the information provided agree to him/her taking part in any or all of the activities described.		
2. I consent to any emergency medical treatment required by my child during the course of the visit.		
3. I confirm that my child is in good health and I consider him/her fit to participate.		
NAME & ADDRESS OF FAMILY DOCTOR:	SURGERY TEL.NO:	
SIGNATURE OF PARENT/GUARDIAN:	DATE:	