



Offsite Activity - Consent & Medical Form

Offsite activity information and consent form (please complete both sides)

Personal Details

First name of participant _____ Surname _____

Tutor Group _____

Date of birth _____ Age _____ Male / Female

Address _____

_____ Post Code _____

Name of next of kin _____

Next of kin address during activity (if different from above) _____

_____ Post Code _____

Contact No:

Home _____ Work _____ Mobile _____

Name and address of participant's doctor _____

Telephone no: _____ NHS no (if known) _____

Consent for activity

Activity _____ Date _____

I confirm that I have parental responsibility for _____

He/she is in good health and I consider him/her to be capable of taking part in the activities set out in your letter. I consent to him/her taking part in the programme detailed in your letter.

In the event of illness or accident, I consent to any necessary medical treatment, which might include the use of anaesthetics.

Signed _____

Please print name here _____



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Has the participant had any of the following?

	Yes	No		Yes	No
Asthma or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to any known medication	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies, e.g. material, food, plasters	<input type="checkbox"/>	<input type="checkbox"/>
Fits, fainting or blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Other illness or disability	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Travel sickness	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Regular medication	<input type="checkbox"/>	<input type="checkbox"/>
			Recent hospital treatment	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to any of these questions is Yes, please give details: _____

	Yes	No
If it is considered necessary, do you agree to mild painkillers (e.g. Paracetamol) being administered.	<input type="checkbox"/>	<input type="checkbox"/>
Has the participant received vaccination against Tetanus in the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>
Has the participant received medical treatment at a hospital in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Is the participant receiving medical or surgical treatment of any kind from either their family doctor or hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Has the participant been given specific medical advice to follow in emergencies?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to either of the last three questions is Yes, please give details here (including name and dosage of any medicines/tablets): _____

In the event of any illness or medical treatment occurring after the return of this form or prior to the activity, I undertake to inform the group leader.

Signed _____ (Person with parental responsibility)

Please print name here _____ Date _____

Consent for taking images

Your consent has already been sought in relation to the use of images. We are however likely to take picture/video during our activity and would like to confirm your consent to use these in presentations, displays or in our own booklets, newsletter or publicity.

In the event of any images of my child being taken, I consent to them being used for educational purposes. Yes No

I consent to the images being used on the school's website Yes No

Signed _____ (Person with parental responsibility)

Please print name here _____ Date _____