STANWELL SCHOOL
SCHOOL VISITS
CONSENT FORM

IN THE CASE OF STUDENTS UNDER THE AGE OF EIGHTEEN YEARS, TO BE COMPLETED BY PARENTS/GUARDIANS

PUPIL NAME:	
HOME ADDRESS:	
TELEPHONE NUMBER:	DATE OF BIRTH:
DOCTORS NAME, ADDRESS AND TELEPHONE NUMBER	

EMERGENCY CONTACT

NAME:	TEL NO:
NAME:	TEL NO:

Please complete as appropriate

My child suffers from

____

requiring regular treatment. (Please include a letter from your own doctor giving details of this particular complaint, including treatment.)

Date of your child's last tetanus injection.

Has your child any known allergy? Please give brief details.

Please outline any special dietary requirements.

I consent to any emergency medical, surgical or dental treatment including anaesthetic, blood transfusion as considered necessary by the medical authorities present during this visit.
I understand the extent and limitations of the insurance cover provided.
I am aware that this visit may include time when pupils will have some time unsupervised and I agree to this aspect.

I will inform the group leader as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.

I consent to my child taking part in the attached visit programme.

Signed: __________________________________ Parent/Guardian Date: ____________________