

# FORM 6



## PARENTAL CONSENT FOR A SCHOOL VISIT

This information you provide will be processed for educational purposes. To ensure confidentiality and privacy, all processing will be carried out under the requirements of the current Jersey Data Protection legislation. This information may be disclosed and used outside the Department where it is considered to be in the pupil's best interests. Your child's name and image may also be included in school and other publications where this is considered not to be against his/her interests. Should you require us to seek your individual consent to these disclosures, please advise us in writing.

School/Group .....

**1. Details of visit to:** .....

I agree to: ..... (name) D.o.B.....  
taking part in this visit and have read the information sheet. I agree:

to ..... 's participation in the activities

described. I acknowledge the need for..... to behave responsibly.

**2. Medical information about your child.**

a) Any conditions requiring medical treatment, including medication or of  
which account should be taken YES/NO  
If YES, please give brief details:

.....  
.....

b) Please outline any special dietary requirements of your child and the type of pain/flu relief medication your child may be given if necessary:

.....  
.....  
.....

For residential visits and exchanges only

c) To the best of your knowledge, has your son/daughter been in contact with anything contagious or suffered from anything in the last four weeks that may be contagious or infectious? YES/NO. If YES, please give brief details:

.....  
.....

d) Is your son/daughter allergic to any medication?

YES/NO

If YES, please specify:

.....  
.....  
.....

e) When did your son/daughter last have a tetanus injection?

.....

I will inform the Group Leader/Headteacher as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.

**3. 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:

Work ..... Home.....

Home address.....

.....

Alternative emergency contact Name.....

Relationship to child ..... Telephone number.....

Address .....

.....

Name of family doctor ..... Telephone number.....

Address .....

.....

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 SCHOOL CONTACT**