Shape, circle

Description automatically generated**Form A**

**General Consent Form**

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| **CONSENT FOR AN ACTIVITY/EVENT** | | | | | |
| 1. **NATURE OF EVENT/ACTIVITY:** | | | | | |
|  | | | | | |
| **Date(s):** |  | **Time(s):** | |  | |
| **Costs** |  | | | | |
| I agree to: *(insert name)*  Date of Birth:   * Their participation in the activities described. * I understand that, while involved, he/she will be under the control and care of the group leader and/or other adults approved by the church/organisation leadership and that, while the staff in charge of the group will take all reasonable care of the children, they cannot necessarily be held responsible for any loss, damage or injury suffered by my child during, or as a result of the activity. * I acknowledge the need for him/her to behave responsibly and will ensure that he/she is aware of the expectation to behave responsibly. | | | | | |
| 1. **TRANSPORT ARRANGEMENTS:**   **(for which parents/carers hold responsibility)**  Please detail how your child will travel to and from the activity or the pick-up point for the day/residential trip. | | | | | |
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| 1. **MEDICAL INFORMATION:** | | | | | |
| 1. **Does your child have any condition(s) requiring medical treatment including medication, e.g. inhalers, anti-epileptics or insulin?** | | | | | |
| **YES** | *If* ***YES*** *please give details* | | **NO** | |  |
| **Details of medical treatment:** | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Please outline any special dietary requirements of your child (including allergies e.g. nuts) and the type of pain/flu relief medication your child may be given if necessary.** | | | | | | | |
|  | | | | | | | |
| 1. **Please outline any FEARS OR PHOBIAS your child has.**   *(This information will assist the adult helpers to assist your child should any difficulties arise)* | | | | | | | |
|  | | | | | | | |
| 1. **Is your child allergic to any medication e.g. penicillin?** | | | | | | | |
| **YES** | *If* ***YES*** *please specify below* | | | **NO** | | |  |
|  | | | | | | | |
| 1. **When did your child last have a tetanus injection?** | | | | | | | |
|  | | | | | | | |
| 1. **Is there any other relevant information/specific requirement(s) that need to be known by the organiser e.g. travel sickness/mobility?** | | | | | | | |
|  | | | | | | | |
| **I will inform the event leader as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.** | | | | | | | |
| 1. **CONTACT INFORMATION** | | | | | | | |
| **Name of Contact** | | |  | | | | |
| **Home Telephone Number** | | |  | | | | |
| **Mobile Telephone Number** | | |  | | | | |
| **Work Telephone Number** | | |  | | | | |
| **Home Address** | | |  | | | | |
| **Alternative emergency contact:** | | | | | | | |
| **Name** | |  | | | | | |
| **Home Telephone Number** | |  | | | | | |
| **Mobile Telephone Number** | |  | | | | | |
| **Work Telephone Number** | |  | | | | | |
| **Home Address** | |  | | | | | |
| **Name of Medical Practice** | |  | | | | | |
| **Practice Telephone Number** | |  | | | | | |
| **Medical Practice Address** | |  | | | | | |
| **FOR RESIDENTIAL TRIPS ONLY – To the best of your knowledge, has your child been in contact with any contagious or infectious diseases or suffered from anything in the last few weeks that may be contagious?** | | | | | | | |
| 1. *If* ***YES*** *please specify below* | | | | | | | |
|  | | | | | | | |
| **I will inform the event leader as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.** | | | | | **Date:** |  | |
| **Full Name:**  *(capitals)* | |  | | | | | |
| **Relationship**  **to child:** | |  | | | | | |
|  | | **Signed by parent or guardian** | | | | | |