

Roman Catholic Diocese of Arundel and Brighton



Form Ref: CaSE 4

PARENTAL CONSENT FOR AN ACTIVITY/EVENT

1. NATURE OF EVENT/ACTIVITY			
Sacred Heart Youth Club CHILL CLUB for Years 7 to 11 (ages 11-16)			
	Friday 3rd Friday of the month, term-time	Time(s)	7 to 8.30 p.m.
<p>I agree to _____ (name) _____ (D.O.B)</p> <ul style="list-style-type: none"> ● I agree to his/her participation in the activities described ● I understand that group/activity photographs may be taken during the event, in line with the Church's policy. I give my consent to this. ● I acknowledge the need for him/her to behave responsibly and will ensure he/she is aware of the expectation to behave responsibly and in accordance with the Code of Conduct for children/ young people (attached). 			
2. TRANSPORT ARRANGEMENTS (for which parents/carers hold responsibility)			
Please detail how your son/daughter will travel to and from the activity or the pick-up point for the day trip/residential trip.			
I GIVE PERMISSION FOR THE ABOVE-NAMED CHILD TO SIGN HIS/HERSELF			
OUT AT THE END OF CHILL CLUB SESSIONS AND UNDERSTAND THAT WHEN HE/SHE			
DOES, HE/SHE WILL CEASE TO BE THE RESPONSIBILITY OF THE CHILL CLUB			
SUPERVISORS. YES/NO (delete as applicable)			
3. MEDICAL INFORMATION ABOUT YOUR CHILD			
a. Any conditions requiring medical treatment including medication e.g. inhalers, anti-epileptics or insulin			
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If YES please give details			

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3. MEDICAL INFORMATION ABOUT YOUR CHILD (cont...)			
b. 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.			
c. Please outline any FEARS OR PHOBIAS your child has. This information will assist the adult helpers to assist your child should any difficulties arise			
d. Is your son/daughter allergic to any medication e.g. penicillin			
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If YES please specify			
e. When did your son/daughter last have a tetanus injection?			
f. Is there any other relevant information/specific needs that need to be known by the organiser? e.g. travel sickness/mobility			
g. FOR RESIDENTIAL TRIPS ONLY To the best of your knowledge, has your son/daughter been in contact with any contagious or infectious diseases or suffered from anything in the last few weeks that may be contagious			
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If YES please specify			

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.

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4. CONTACT TELEPHONE NUMBERS:			
Work/Mobile:		Home:	
Email Address			
Home Address:			
Alternative emergency contact:			
Name:		Telephone Number:	
Address:			
Name of Family Doctor:		Telephone Number:	
Address:			

5. DECLARATION			
<p>In the event of an illness or accident every effort will be made by the event leader or their assistants to contact me. If for whatever reason this is not possible 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</p>			
Signed:		Date:	
Full Name (Capitals):			