HUNSLEY PRIMARY
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East Dale Rd, Melton,
North Ferriby HU14 3HS
Telephone 01482 330883
Enquiries@HunsleyPrimary.org.uk
HunsleyPrimary.org.uk

Our ref: HP59

9 March 2016

Dear Parent/Carer

**Re: Easter walk to visit Welton Church – Wednesday 23 March 2016**

We are pleased to be able to offer your child the opportunity to participate in our Easter walk to visit Welton Church during the afternoon of Wednesday 23 March.

Our Easter walk will give the children an opportunity to look at the changes in the natural landscape and to explore the church grounds. The children will be accompanied by staff and will require waterproof jackets and wellingtons.

We will walk the children to the Church after lunch and will be back at school before 3.30pm.

If you would like your child to participate in this visit please complete the slip below and the attached Medical Consent form and return it to Mrs Hitchin by Friday 18 March.

Yours faithfully

Lucy Hudson
**Head of Hunsley Primary**

✂ ----------

**Easter walk to visit Welton Church**
**Wednesday 23 March 2016**

I wish my son/daughter _____ (Pupil's Name) to participate in the Easter walk to visit Welton Church on Wednesday 23 March.

Signed_____(Parent/Carer) _____ (Date)

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# Offsite Visits – Personal and Medical Information and Consent Form (C3)

## HP59 – Easter walk to visit Welton Church

**INFORMATION FOR PARENTS/GUARDIANS/CARERS**

Please complete the questions below and sign the consent. The personal and medical information requested is vital to ensure that appropriate care and support is available for each child. Please consult your family doctor if you are unsure about the suitability of a visit. Medical conditions will not necessarily exclude any child from participating in activities, but leaders should be made aware of anything that might affect the safety/welfare of this child or others in the group.

| PERSONAL DETAILS | | | | |
|---|---|---|---|---|
| **PUPIL** | | **PARENT/GUARDIAN/CARER INFORMATION** | | |
| **Surname** | | **Name** | | **Form:** |
| **First Name** | | **Address** | | |
| **Address**<br><br>**Postcode** | | <br><br>**Postcode** | | |
| | | **Telephone Numbers** | | |
| **Date of Birth** | | **Day** | **Evening** | **Mobile** |
| | | | | |
| **Doctor** | | **Additional Emergency Contact** | | |
| **Surgery Address** | | **Name** | | |
| | | **Relationship** | | |
| | | **Address** | | |
| **Telephone No** | | **Telephone** | | |

**DIETARY INFORMATION**

If this child has any specific dietary needs (e.g. vegetarian), please give details here:

**MEDICAL or SPECIAL NEEDS**

**Please provide all relevant information which will enable Leaders to safely care for this child (please circle answers):**

| | | |
|---|---|---|
| Does this child have any significant allergies (including to medication)? | **Yes** | **No** |
| Does this child have any medical conditions, impairments, or disabilities? | **Yes** | **No** |
| Has this child had any recent significant illnesses or injuries? | **Yes** | **No** |
| If a residential visit, does this child have any night-time tendencies (e.g. sleepwalking, nightmares, bed-wetting) which might cause him/her concern? | **Yes** | **No** |

**If the answer is "yes" to any of these questions, please give full details below (use an additional sheet if necessary):**

**PERSONAL MEDICATION**

It is important that this child is accompanied by any medication necessary, and that leaders are fully informed. Please make sure that there is sufficient medication, and that it is clearly labelled.

| Name of Medication | Dosage | Time and Frequency or circumstances to be given | Method of Administration |
|---|---|---|---|
| | | | |

| Please state any special precautions, side effects of medication (if applicable): |
|---|
| |

| | | |
|---|---|---|
| **I give my consent** for a member of staff to administer the above medication which I will deliver to the Overall Group Leader before the visit, together with clear labels and instructions. I understand that the staff leading the visit are not qualified medical practitioners, but that they will take reasonable care in the administration of the medication. | **Yes** | **No** |
| **I give my consent** for this child to self-administer the above medication. | **Yes** | **No** |
| To the best of your knowledge, has this child been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be, or become, contagious or infectious? (please circle answer) | **Yes** | **No** |
| **If YES, please give brief details:** | | |
| Does this child have up-to-date protection against tetanus (normally an injection within the past 10 years)? | **Yes** | **No** |

**MINOR MEDICAL TREATMENT DURING VISITS**

Young people sometimes need minor medical treatment for conditions such as headaches, rashes, coughs & colds, insect bites, etc. If necessary, with your permission, staff will treat these ailments with the following "off the shelf" products which are commonly available from most chemists:
Paracetamol, throat lozenges, cough mixture, antiseptic cream, calamine lotion, antiseptic wipes, hypoallergenic adhesive plasters, witch hazel, insect bite antihistamine, suncream.

| | | |
|---|---|---|
| Please state clearly below if you do not wish this child to be given any of the products mentioned above (or if other alternatives are acceptable or preferred instead): | | |
| Are you willing for this child to be given these products, if required? (circle answer) | **Yes** | **No** |

| **MAJOR MEDICAL TREATMENT DURING VISITS** | | |
|---|---|---|
| Do you **agree** to this child receiving emergency medical or dental treatment if it is considered necessary by the medical authorities present, and if it has not been possible to contact you beforehand? In such extreme and unlikely circumstances, the Overall Group Leader would be authorized on your behalf to give consent to any emergency treatment. (please circle answer) | **Yes** | **No** |
| If this is not acceptable, please state clearly your preferred alternative: | | |

**PARENT/CARER/GUARDIAN DECLARATIONS and CONSENT**

- **I am legally responsible for the care of the child mentioned above.**
- **I have listed all relevant medical or other conditions** concerning this child that might affect the duty of care expected during an educational visit.
- **I undertake** to inform the Overall Group Leader/Headteacher (in writing) of any changes in the medical or other circumstances of this child before the date of departure.

| | |
|---|---|
| Signed: | Name: |
| Date: | Relationship: Parent/Carer/Guardian (delete) |
| Signed: | Name: |
| Date: | Relationship: Parent/Carer/Guardian (delete) |