

Contact details :

NAME: Email :

HOME/WORK: MOBILE:

HOME ADDRESS:

.....

Alternative emergency:

NAME: Email :

HOME/WORK: MOBILE:

HOME ADDRESS:

.....

DECLARATION

I agree to my child 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. (Insurance details are available on request from the Finance Office.)

SIGNED: **DATE:** ____/____/____

Full name: (please print)

***Participation in the visit is conditional upon satisfactory behaviour during the period leading up to the visit. The school reserves the right to withdraw a student at any point where there are concerns.**

**THIS FORM OR A COPY MUST BE TAKEN BY THE GROUP LEADER ON THE VISIT.
A COPY SHOULD BE RETAINED BY THE SCHOOL CONTACT**