Appendix 1
Parental consent for an educational visit

The information you provide will be processed for educational purposes and for the purposes of administering the visit. This information may be disclosed and used outside the Department only under the provisions of the Data Protection (Jersey) Law 2018, for example for vital interests (safeguarding) or with your consent.

School/Group

Details of visit to:

Pupil Name:		DOB:	

I agree to my child taking part in this visit. I have read and understand the information provided about this visit, and I agree to my child taking part in the activities described. I also acknowledge the need for my child to behave responsibly.

Medical Information about your child

Please give details of any condition requiring medical treatment, including any medication. Conditions including asthma, bronchitis, heart condition, fits, fainting, diabetes, severe or prolonged headaches, allergies to foods/ medication/plasters, sensory difficulties, severe travel sickness, or ANY other condition or disability which may affect your child's ability to take part must be listed. If none, please write NONE in the space below

Please outline any special dietary requirements

Do you consent to your child being given non-prescription pain relief and other over the counter medication, if necessary? Yes ☐ No ☐

If Yes what is the preferred type of pain relief? For example, Paracetamol.

Has your child had a tetanus injection in the last 10 years? Yes ☐ No ☐

Doctors Name & Surgery:

I agree to inform the Group Leader as soon as possible, of any changes to medical information or other circumstances between now and the start of the visit.

Please complete the contact information and sign the declaration overleaf

Contact details

Primary Contact:		Relationship:	

Home Tel:		Work Tel:		Mobile:	

Alternative Contact

Primary Contact:		Relationship:	

Home Tel:		Work Tel:		Mobile:	

Declaration

I agree to my son/daughter taking part in the educational visit outlined overleaf. I agree to my son/daughter receiving medical treatment including surgical treatment, emergency dental treatment, medication, anaesthetic or blood transfusion, as considered necessary by the medical authorities present. I understand the extent and limitations of any insurance cover provided.

Should vaccination or other planned medication be a condition of participation in this visit, I agree to ensure that this is carried out as detailed by the group leader. Should I fail to carry out this requirement, I accept my child may be excluded from the visit, and no refund will be applicable.

Signed:		Date:	

Full Name:		Relationship:	

I confirm that I have parental responsibility* for the named child YES ☐ NO ☐

* You must have Parental Responsibility to consent to medical treatment for your child. For a Jersey born child, you have Parental Responsibility if you are the child's mother / have a custody order or residence order for the child / have responsibility under an emergency protection order for the child / are a guardian of the child / have adopted the child / are the child's father and you were married to the child's mother when the child was born (in which case you will normally share responsibility with the mother) / you are the child's father and you were not married to the child's mother when the child was born but have from the Court a residence order or a parental responsibility order or have entered into a parental responsibility agreement with the child's mother or have since married the child's mother. For a child born in another jurisdiction, you have Parental Responsibility if you are the child's mother or are named as the child's father on the birth certificate.

Please use this space to provide any other information, which you may consider to be of use to the group leader.

For school use only. Update of any medical information: