



PARENTAL CONSENT FORM

Establishment: THE MARLBOROUGH SCIENCE ACADEMY

To be completed by Group Leader/Organiser

Visit:	Berlin	
Group Leader:	Mr Ben Corbett	
Date of Visit:	14 th February 2015	17 th February 2015
Is a photograph of participant required:	No	

To be completed by the parent/adult responsible for a child/young person.

Child/Young Persons Full Name:

Date of Birth:

Does the above person:

- Have a medical condition requiring medical treatment or medication? Y/N
- Have an allergy to certain medications? Y/N

Is he/she able to administer his/her own medication? Y/N

Please give details of medical condition/treatments or allergies to medications below:

Has he/she been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may become contagious or infectious? Y/N

If yes, give details:

Has he/she received a tetanus injection in the last 5 years? Y/N

Does he/she have any special dietary requirements? Y/N

If yes, give details:

I wish to draw the following to the Group Leader attention (e.g. allergies, phobias, travel sickness, toileting difficulties, sleep walking, recent operations or treatments, other conditions which may affect fitness to participate in certain activities):

SWIMMING ABILITY (where swimming activities are planned)

I confirm that _____ (name) is:

Water confident and able to swim 25 metres.

EMERGENCY CONTACT INFORMATION

MAIN

ALTERNATIVE

Name:

Relationship:

Address:

Telephone Numbers: Home:
Work:
Mobile:
Other:

FAMILY DOCTOR DETAILS

Name:

Address:

Telephone Numbers:

National Health Number:

DECLARATION: I have received and understood the details of the visit.

I agree that (full name of child/young person) _____:

- can participate in the visit and activities described;
- can be transported in the private vehicles of staff/volunteers supervising the visit;
- is in good health and fit to participate in the activities described;
- can receive medical treatment as necessary.

I undertake to inform the Group Leader as soon as possible of any change in medical circumstances.

I acknowledge the need for the person named above to behave responsibly and agree to the establishment's procedures in this respect.

Signed:

Name in Capitals:

Relationship

Date:

Address:

Postcode:

Telephone No:

Where required, has a passport sized photograph been attached:

Yes
No
Not required

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