



# CONFIDENTIAL PARENTAL CONSENT FORM FOR Visits to Environmental Education Residential Centres (to be distributed with full details of the visit)

**1. Consent for participation in the visit**

Visit to: **CASTLETON LOSEHILL HALL RESIDENTIAL VISIT**

Date(s)/Times: From: **Monday 15<sup>th</sup> September 2025 to Wednesday 17<sup>th</sup> September 2025**

**I agree to my son/daughter** \_\_\_\_\_ **(name)** taking part in the above-mentioned visit and, having read the information provided, agree to his/her participation in any or all of the activities\* described. I acknowledge the need for obedience and responsible behaviour on his/her part. I understand that there is some level of risk in every activity but that this visit will be managed to minimise the risks involved. I understand the extent and limitations of the insurance cover provided. I understand that as part of the planned transport arrangements, or in emergency, it may be necessary for pupils to be transported in staff vehicles.

\* If there are any activities in which your child cannot participate, please give details:

**I give permission** for my son/daughter's name to be included in the collective passport to be held by the group leader  
**YES / NO / NOT APPLICABLE**

If water activities are involved, is your child confident in water? **YES / NO / NOT APPLICABLE**

**2. Medical information, declarations and consent**

a) Son/daughter's date of birth: \_\_\_\_\_

b) Does your son/daughter suffer from any conditions of which the teacher leading the visit should be aware: **YES/NO**  
If YES, please give details of anything the leader needs to know about to safety care for your child e.g. illness, travel sickness, allergies, night-time tendencies (sleepwalking, nightmares, bed-wetting) etc.

c) Details of any medication

Name of medication	Dosage	Times of day or circumstances to be given	Method of administration

Any special precautions, side effects of medication etc:

**I give my consent** \*\* for a member of staff to administer the above medication which I will deliver to the group leader before the visit. I understand the staff leading the visit are not qualified medical practitioners but that they will take reasonable care in the administration of the medication and will endeavour to respond appropriately should emergency treatment be required.  
**PLEASE ADVISE THE SCHOOL OFFICE OF ANY CHANGES TO MEDICATION AT LEAST 5 DAYS BEFORE THE START OF THE TRIP.**

**I give my consent** \*\* for my son/daughter to self-administer the above drugs.

\*\* delete if not applicable

d) 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 four weeks that may be, or become, contagious or infectious? : **YES/NO**  
If YES, please give brief details.

- e) Is your son/daughter allergic to any medication: **YES/NO** If **YES**, please specify.
- f) When did your son/daughter last receive a tetanus injection?
- g) Please outline any special dietary requirements of your child:
- h) **I undertake** to inform the group leader/ head teacher as soon as possible of any change in the medical or other circumstances between now and the commencement of the journey.
- i) **I agree** to my son/daughter receiving emergency medical treatment, including anaesthetic and blood transfusion, as considered necessary by the medical authorities present.

**3. Photograph Consent**

- a) Nottinghamshire County Council occasionally uses photographs for promotional purposes (for our publications and/or website to promote the value of outdoor and environmental education). To comply with the Data Protection Act 1998, we need your permission before we use any photographs we have taken.

**I give consent** for my son/daughter's photograph to be used by Nottinghamshire County Council: **YES/NO**

**4. Contact numbers**

- a) I may be contacted by telephoning the following numbers:

Work: \_\_\_\_\_ Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

My home address is: \_\_\_\_\_

\_\_\_\_\_

- b) If I am not available, please contact:

Name: \_\_\_\_\_ Telephone Numbers: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

- c) Name, address and telephone number of family doctor: \_\_\_\_\_

\_\_\_\_\_

**5. Any other relevant information**

**6. Signature**

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Full name (capitals): \_\_\_\_\_