**Young People’s Event Parental Consent Form**

|  |  |
| --- | --- |
| Event and Date of Event |  |
| Name of Child and DOB |  |

I agree to my son / daughter (name)  taking part in the above-mentioned event and, having read the information provided, agree to his / her participation in any or all of the activities described. I acknowledge the need for cooperation with staff and responsible behaviour on his / her part. I understand that there is some level of risk in ever activity but that this event will managed to minimise the risks involved. I understand that as part of any planned transport arrangements, or in an emergency, it may be necessary for participants to be transported in staff vehicle.

I understand the staff leading the visit are not qualified medical practitioners but that they will take reasonable care and will endeavour to respond appropriately should emergency treatment be required.

Parent Name:

Parent Signature:

Email Address:

Home Address:

Emergency contact telephone numbers during the day. Please provide two contact numbers.

Name and Number:

Name and Number:

|  |
| --- |
| Please specify any specific needs or allergies |

GP Name:

GP Contact Number:

**Photo Consent**

As part of the event we may also take a photograph/image that **will not** show your child’s face to use in future promotional materials.

Do you consent to your child’s photo being taken? (Please circle as appropriate) **YES / NO**

**Please return consent forms to:**

Adoption.learning@adoptioneastmidlands.nottscc.gov.uk

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**Medication Consent Form**

**Please only complete if your child needs medication during the event.**

I, parent of (name)  give permission for either (please tick as appropriate):

* An Adoption East Midlands staff member to give my son / daughter
* My child to self-administer

The following **PRESCRIBED** medication (medicines **must** be in original container):

Full name of medicine:   
Dosage:   
Time to be administered:   
How the medication is administered:

I understand the staff leading the event 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.

Parent Name (printed)

Parent Signature

Parent Contact Number

Date

**For office use only**

The above medication as administered at (time)

Staff Member Name

Staff Member Signature

Date

**Please return consent form to:**

Adoption.learning@adoptioneastmidlands.nottscc.gov.uk 