|  |
| --- |
| **Information on excursion for Parent/Carer – Please cut off and retain:**  Destination and cost:  Date and Time:  Member of staff responsible: |

**✂- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -✂ - - - - - - - - - - -- - - - - - - - - - - - - - - - - - - - - - -✂**

**Complete and Return this section to school:**

Excursion: Date:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

🕿 School hours \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🕿 Other times \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🕿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relevant medical details (e.g. asthma): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I agree to my child taking part in the above excursion:**

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

**I CAN/CANNOT BE A PARENT HELPER ON THIS OUTING (must be disclosure checked)**

**PACKED LUNCH REQUIRED [ ] DRINK AND SNACK REQUIRED [ ]**

**OTHER INFO:**

**Parental/carer agreement to receiving emergency medical treatment**

Pupil Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, telephone number and address of Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please read the two statements below, tick one option and cross out the other.**

|  |  |
| --- | --- |
| ❒  I agree to my child receiving emergency medical treatment, including blood transfusion, and anaesthetic as considered necessary by the medical authorities present. | ❒  I agree to my child receiving medical treatment/anaesthetic as considered necessary by the medical authorities present with the exception of the administration of blood or blood products. I accept full legal responsibility for this decision and release West Lothian Council and its staff from any liability for any consequences resulting from my decision not to consent to the transfusion of blood or blood products |
|  |  |

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed by Parent/Carer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed for excursions involving an overnight stay or outdoor education**

|  |  |
| --- | --- |
| Does your child suffer from any allergies? |  |
| Is your child taking any medication at present? |  |
| Does your child suffer from any condition that may affect participation? |  |
| Has your child been in contact with any contagious or infectious disease or suffered from anything in the past four weeks that may become Infectious or contagious? |  |
| When did your last have a tetanus injection? |  |
| Does your child have any special dietary requirements? |  |
| Is there any activity in which your child must not participate? |  |
| Further information: | |