

# DURRINGTON HIGH SCHOOL – DofE 2020

## Parent/Carer Consent Form

Saturday 15 <sup>th</sup> February (half-term)	Familiarisation hikes	accompanied
Friday 3 <sup>rd</sup> - Saturday 4 <sup>th</sup> April	Assessment hikes	accompanied
Friday 8 <sup>th</sup> - Saturday 9 <sup>h</sup> May	DofE Qualifier Expedition #1**	unaccompanied *
Saturday 20 <sup>th</sup> June	Navigation hike	unaccompanied *
Saturday 4 <sup>th</sup> -Sunday 5 <sup>th</sup> July	DofE Qualifier Expedition #2**	unaccompanied *

\* Unaccompanied events are supported through remote supervision and meeting students at safety checkpoints.

\*\* For over-night events support staff will be present on the campsite.

**Name of Student** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Tutor Group** \_\_\_\_\_  
**(Full name of child in capitals)**

I agree to my child taking part in the above mentioned activities and, having read the information sheet, agree to them taking part in any or all of the activities described.

I have ensured that my child understands that it is important for their safety and for the safety of others of the group that any rules and any instructions given by staff are followed.

**I understand that, while the school staff and helpers in charge of the party will take all reasonable care of the young people, unless they are negligent, they cannot be held responsible for any loss, damage or injury suffered by my child arising during or out of the journey.**

EMERGENCY CONTACT 1	EMERGENCY CONTACT 2
Name: .....	Name: .....
Address:..... .....	Address: .....
Relationship to Child: .....	Relationship to Child: .....
Emergency Contact Number 1: .....	Emergency Contact Number 1: .....
Emergency Contact Number: 2: .....	Emergency Contact Number: 2: .....

### Medical Information

Name of Doctor	Doctor's Address and Telephone Number

**PLEASE TURN OVER**

Please delete and complete the following, as is appropriate:

- My child has**
- a) no illness, allergy or physical disability
  - b) has the following illness, allergy or physical disability which necessitates the following medical treatment:

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**I agree that if it becomes necessary for my child to receive medical treatment and I cannot be contacted to authorise this, I hereby give my general consent to any necessary medical treatment and authorise the Leader in charge to sign any documents required by medical authorities. YES/NO (please delete as appropriate)**

**Other relevant information**

Please give details of any further information you believe the staff should be aware of (including travel sickness). Particular consideration should be given to Asthma, Diabetes and Epilepsy. Any emotional or sleeping problems e.g. sleep walking or bed-wetting (**residential trips only**), should also be included.

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Does your child need any medications (including inhalers or travel medicine)? YES / NO (please circle)

Has your child received vaccinations against tetanus in the last ten years? YES / NO (please circle)

Is your child currently receiving medical treatment of any kind from either your family doctor or hospital? YES / NO (please circle)

Has your child been given specific medical advice to follow in emergencies? YES / NO (please circle)

If the answer to any of the above questions is YES, please give details here (including dosage of any medicines/tablets)

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**If your child has been hospitalised and/or has had medical treatment in the last 12 months, please give full details and attach to this form. *Non-disclosure of relevant information can invalidate insurance.***

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Signed: ..... Parent/Guardian Date: .....