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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Dyce Academy Sponsored Walk  consent form V4 | | | | | | | | | | | | | | | | | | | | |
| **VISIT TO** | | | Sponsored walk from Dyce Academy to Udny Station to Newmachar | | | | | | | | | | | | **DATE** | | | | 17/09/2014 | |
| LEADER | | | L Adam | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **VISIT MEMBER** | | | | | | |  | | | | | | | **AGE & D.O.B.** | | | | |  | |
| Address | | | | | | |  | | | | | | | | | | | | | |
| Parent / Carer name (if applicable) | | | | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **EMERGENCY CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| First option - Name | | | | | |  | | | | | | | Tel (home) | | | |  | | | |
| Address | | | | | |  | | | | | | | Tel (mobile) | | | |  | | | |
| Second option - Name | | | | | |  | | | | | | | Tel (home) | | | |  | | | |
| Address | | | | | |  | | | | | | | Tel (mobile) | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **SWIMMING – For water based activities and swimming pools N/A** | | | | | | | | | | | | | | | | | | | | |
| Can the above named person swim YES  NO  If yes, how far do you think they can swim ……metres. If they can not swim would they be confident in water with an approved buoyancy aid or life jacket YES  NO  **N/A** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **MEDICAL – Please give full and accurate information** | | | | | | | | | | | | | | | | | | | | |
| Doctors name |  | | | | | | | | Practice | |  | | | | | | Tel |  | | |
| Recent medical issues / illnesses / surgery | | | | | | | |  | | | | | | | | | | | | |
| Has your child / ward been in close contact with any contagious diseases? | | | | | | | | | | | | | | | | | | | | |
| If yes please give details | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Any infections in the last 4 weeks | | | | |  | | | | | | | | | | | | | | | |
| Any current course of medication | | | | |  | | | | | | | | | | | | | | | |
| Any restrictions you would wish to place on emergency treatment: | | | | | | | | | | | | | | | | | | | | |
| I authorise all medical and surgical treatment, including X-ray, laboratory, anaesthesia and other medical and/or hospital procedures as may be performed or prescribed by the attending doctor and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/carer can be reached in the case of an emergency. | | | | | | | | | | | | | | | | | | | | |
| Parent / Carer’s signature | |  | | | | | | | | | | | | | | Date | |  | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **PHOTOGRAPHY** | | | | | | | | | | | | | | | | | | | | |
| Please tick the box If you do not consent to photographs being taken of your child / ward that could be used to promote activities in the Establishment / Council. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| CONSENT | | | | | | | | | | | | | | | | | | | | |
| I, being over 18yrs of age or having parental rights and responsibilities towards the above named person understand the nature of the visit / activities and agree to them taking part and that they are fit and able to do so. **By signing this form I agree to Aberdeen City Council’s terms and conditions which can be found at www.aberdeencity.gov.uk/adventureaberdeen and also understand that it is my responsibility to inform the visit leader of any significant changes to the information I have provided about the person named in this form between now and the visit taking place.** | | | | | | | | | | | | | | | | | | | | |
| Name  (Block Capitals) | | | |  | | | | | | Signature | |  | | | | | | Date | |  |
| Name (Counter signature for young persons 16 – 18) | | | |  | | | | | | Signature | |  | | | | | | Date | |  |