|  |  |
| --- | --- |
|  | ***Holy Name Catholic Primary School***  ***Vergam Terrace***  ***Fishguard***  ***Pembrokeshire***  ***SA65 9DF***  ***Tel/Fax: 01348 872506*** |

***­***

**Educational Visit Form – Parental Information**

This part to be kept by parent/guardian.

Details of Educational Visit:

Visit to: **Local Schools Rugby Tournament, the Grange**

On (date): **Friday, July 13th, 2018**

Start time: **10:30 am**  Finish time: **3:00 pm approx**

Purpose of visit/proposed activities:

**Take part in Rugby Tournament**

Means of Transport: **Walking**

Group Leader: Accompanying Staff:

**Miss C Richards**

Voluntary contribution:

Additional information:

**Children will need their School PE Kit, astroturf boots/trainers or rugby boots, trainers, shin pads and gum shield (for those playing contact), packed lunch, drink and clothing suitable for the weather and suncream/sun hat. There is food available to buy so pupils can bring money. No electronic devices, including mobile phones**

|  |  |
| --- | --- |
|  | ***Holy Name Catholic Primary School*** |

**Educational Visit Consent Form**

Please complete and return to the Group Leader on or before **11/07/18**

I have noted the details of the proposed educational visit to **Local Schools** **Rugby Tournament, the Grange.**

I agree to …………………………… (Name) taking part in this visit and the activities described. I acknowledge the need for my child to behave responsibly.

I enclose a contribution of £……………………….

Parent/Guardian Name ………………………….. Signed ………………………..

Date …………………………..

**Medical Information about your child**

Please list below any medical conditions the group leader should be aware of e.g., asthma, allergies, travel sickness, toileting, etc.

…………………………………………………………………………………………………..

Please indicate details of any medication your child is receiving at the moment or will need to take on the visit.

…………………………………………………………………………………………………

…………………………………………………………………………………………………

I agree to my child receiving medication as instructed and any emergency treatment required as considered necessary by the medical authorities.

Parent/Guardian Name ………………………….. Signed ………………………..

Date …………………………..

Contact Telephone numbers:

Work: …………………………………… Home …………………………………

Home Address: …………………………………………………………………………………..

Alternative Emergency Contact:

Name: …………………………………… Telephone no. …………………………

Address: ……………………………………………………………………………………………

Name of Family Doctor: ……………………….. Telephone no. …………………