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|  | PARENTAL CONSENT FORM Adventurous Activities |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of participant |  | Age |  |

|  |  |
| --- | --- |
| I confirm that I am the Parent/Guardian with parental rights and responsibilities for the above named. | Initial here |

**Activity Details**

|  |  |
| --- | --- |
| Activity at: (location) |  |
| on: (dates) |  |
| Provided by: (activity provider) |  |
| and Led by: (group leader) |  |

The planned excursion will take place according to Moray Council’s Excursion Policy.

Where the activity is deemed adventurous, the excursion arrangements will be examined by Adventure Scotland who provide technical advice to the Head of Establishment prior to approval.

The excursion will be risk assessed and managed in accordance with the policy and every effort will be made to minimise hazards. Nevertheless it is not possible to provide guarantees that every environment encountered during the excursion will be completely risk free. Whilst it is not anticipated that risks will exceed those normally incurred in this activity and those normally incurred in day to day living, in signing the parental consent form you are asked to acknowledge that a degree of risk remains.

Moray Council provides third party public liability insurance for all our excursions. Parents who require personal injury or accident cover for their child/children should organise this privately.

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| --- | --- |
| I confirm that I have received the activity information details accompanying this form. I understand the nature of the activity(s) to be undertaken by my Child/Ward and consider Him/Her fit to take part. | Initial here |
|  |  |
| I confirm that I have read and understood the statement about residual risk and insurance. | Initial here |

**For water-based activities only:**

|  |  |
| --- | --- |
| I certify that my Child/Ward \****is / is not*** water confident and that he/she \****can/cannot*** swim up to 50 meters.   1. Delete as appropriate. | Initial here |

**Emergency contact Details**

It is important that either yourself or another adult prepared to take temporary responsibility for your child/ward is contactable for the duration of the activity/event. Please give details:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of person to contact | |  | | | | |
| Address | |  | | | | |
|  | |  | | | | |
| Home Tel No: |  | | Work Tel No: | | |  |
| Relationship to participant | |  | | | | |
| Name of Parent/Guardian with parental rights and responsibilities: | | | | | | |
| (Block Capitals) | |  | | | | |
| Relationship to participant | |  | | | | |
| Address | |  | | | | |
|  | |  | | | | |
| Home Tel No: |  | | Work Tel No: | |  | |
|  |  | |  | |  | |
| Signature: |  | | | Date: |  | |

**Medical Information and Consent:**

In the event of an emergency, it is important that the person in charge of the group has the necessary information about any medical condition which could affect the care and treatment of your child/ward. All information requested will be treated in strict confidence and will not necessarily prejudice the inclusion of your child/ward in the activity. It is in the interests of your child/ward that full and accurate information be given.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Recent surgery for |  | | | | Date |  |
|  | | | | | | |
| Any known allergy to medicine (e.g. penicillin) | | |  | | | |
|  | | |  | | | |
| Is your child undergoing treatment by a doctor? (If so, please give details) | | | | | | |
|  | | | | | | |
|  | | | | | | |
| Any medical condition which a doctor should know before carrying out treatment (e.g. Asthma) | | | | | | |
|  | | | | | | |
|  | | | | | | |
| Please state any restrictions you wish to place on emergency medical treatment | | | | | | |
|  | | | | | | |
|  | | | | | | |
| Please give details of any special diets e.g. vegetarian/diabetic/no specific "E" numbers etc. | | | | | | |
|  | | | | | | |
|  | | | | | | |
| Any additional information including any current medication, dosages and who should administer. Any allergies or phobias. | | | | | | |
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|  | | | | | | |
| Name of Family Doctor | |  | | | | |
| Address: | |  | | | | |
|  | |  | | | | |
| Tel No: | |  | |  | | |

|  |  |
| --- | --- |
| I hereby consent to the submission of the above-named to emergency medical or surgical treatment including the administration where necessary, of a local, general, or other anaesthetic. |  |
| I understand that in terms of The Age of Legal Capacity (Scotland) Act 1991 Section 1 Pt 2 (4) (see extract below) my child/ward may also consent to his/her own medical treatment if the doctor attending is of the opinion that he/she understands the nature and consequences of such treatment. | Initial here |

***The Age of Legal Capacity (Scotland) Act 1991 Section 1 Pt 2 (4)***

*(4) A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.*

**Declaration**

I hereby give consent for my child/ward to take part in the above activity and confirm that my initials placed in the boxes above indicate that I fully understand the various implications of my consent.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date: |  |

**NB If you are unable to initial any one or more of the boxes above but still wish your child/ward to take part, please contact the party leader.**

**If you are having difficulty with reading or translating this form and the information sent with it you should contact the party leader.**