**PARENTAL CONSENT FORM**

*Thank you for taking the time to complete this form. All the information will be held in confidence and be used only to ensure the safety of your son/daughter.*

***Without a completed form your son / daughter will not be able to attend supervised youth events.***

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| **Details**Name of Group: **14+ YOUTH GROUP**Head of Programme: Parish priestNormal venue for meeting: Hall / ChurchName of child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ School year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Contact Information**Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best Phone number(s) in emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alternative Phone number(s) in emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medical Information** 1. Does your child have any condition/s requiring medical treatment including medication e.g. inhalers, anti-epileptics or insulin? **Yes / No**

 If yes, please give details below and ensure that your child brings any medication they  need with them to each meeting.1. Does your child have any special dietary requirements (including allergies e.g. nuts)? **Yes / No**

If yes, please give details below.1. Is your son/daughter allergic to any medication e.g. penicillin? **Yes / No**

If yes, please give details below.1. Is there any other relevant information/specific requirements that need to be known by the leader, for example in relation to mobility or phobias? **Yes / No**

If yes, please give details below.**I agree to inform the group leader, Catechist or Priest as soon as possible of any changes in the medical needs of my son /daughter.** |
| **Declaration**I understand that in the event of an illness or accident every effort will be made by the group leader or assistants to contact me. If for whatever reason this is not possible, I agree to my son/daughter receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Full name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |