**Parental consent form**

**Name of School**

**PARENTAL CONSENT FORM: ASHA PROJECT TEAM INDIA TRIP (To be retained by the school)**

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| --- | --- | --- | --- | --- |
| Pupil’s Surname (as passport) | Christian Name(s) (as passport) | Year | DOB | Pupil’s Mobile Number |
| Address ……………………………………………………………………………….  ……………………………………………………………… Postcode …………………………………. | | | | |
| Parental Telephone Numbers  Home ………………..…….. Work…………………….… Mobile ………………….………….…….  Alternative Emergency Contact  Name ………………………………….. Telephone number ……………………………….. | | | | |
| **Parental Consent**: I give permission for the pupil named above to participate in the ***Asha Project Team India Trip*** and all its associated activities including **evening** **Team Training Sessions and a Residential**. I agree to him/her taking part in all of the activities involved as I believe him/her to be medically fit to do so. I understand that while staff will take all reasonable care of the pupils, they cannot be held responsible for any loss, damage or injury suffered by my son/daughter which occurs as a result of the trip. I give my consent for any emergency medical, surgical or dental treatment which may be necessary.  I am aware that school Code of Conduct applies fully to this Trip/Activity.  Signature of Parent ……………………………………. Date……………..……… | | | | |
| **Form of Indemnity**  I agree to the school’s offer to take my child on the ***Asha Project Team India Trip***  I have read the information attached and agree to indemnify any member of staff involved against:  1. Any claim made against them by a third party directly or indirectly arising out of any act or default of my son/daughter  2. Any costs and expenses incurred and any/or any other sums disbursed by them or as a results of the above trip, on behalf of my son/daughter  3. Any loss to them from damage to or loss of property or personal injury contributed to or caused by any act or default of my son/daughter  Signature of Parent ……………………………………. Date……………..……… | | | | |
| **Medical conditions / dietary needs (if any):**  ……………………………………………………………………………………………………………  ……………………………………………………………………………………………………………  I consent to my son/daughter receiving the following medication/treatment if thought appropriate . (*Tick appropriate box).*  The provision of Paracetamol (2 x 500mg) 􀂾 yes 􀂾 no  The provision of Hypoallergenic plasters 􀂾 yes 􀂾 no | | | | |

***Please ensure that your son/daughter has an valid individual passport***