



THE HIGH WYCOMBE MUSIC CENTRE

Millbrook Combined School, Mill End Road, High Wycombe, HP12 4BA

Telephone 01494 475166; Facsimile. 01494 442773

E-mail: hwmusic@buckscc.gov.uk Web Site: www.buckscc.gov.uk/hwmc

Area Headteacher:
Simon Salisbury

Deputy Area Headteacher:
Andy Rogers



PARENTAL CONSENT FORM

STUDENT'S NAME: DOB:

MUSIC CENTRE GROUP: **Concert Band / Youth Orchestra / Youth Choir / Guitar Consort / Clarinet Choir**

VISIT TO: **Veneto, Italy – staying at Hotel Park Venezia, Stra**

DATE OF VISIT: **Sat 21st July 2012 (depart HWMC, 2pm) – Sat 28th July 2012 (arrive HWMC, 10.30pm)**

MEDICAL INFORMATION ABOUT YOUR CHILD

Any conditions requiring medical treatment, including medication? Yes No
If YES, please give brief details:

What type of pain/flu relief medication can your child be given, if necessary?
.....

Is your son/daughter allergic to any medication? Yes No
If YES, please specify:

When was the last time your child received a tetanus injection?
.....

DIETARY REQUIREMENTS

Please give specific details of any special dietary requirements of your child (meat / fish / eggs / diary / nuts etc):

.....
.....
.....

Is your child vegetarian?: Yes No

DECLARATION

I agree to my son/daughter taking part in this visit and have read the information distributed. I agree to his/her participation in the activities described and acknowledge the need for him/her to accept the party's code of conduct and behave responsibly.

I agree to my son/daughter receiving medication as instructed, and any urgent dental, medical or surgical treatment, including anesthetic or blood transfusion, as considered necessary by the medical authorities present. I understand the extent and limitations of the insurance cover provided.

I will inform the Group Leader/Headteacher as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.

SIGNED:..... DATE:

FULL NAME (Capitals)
.....

ADDRESS:
.....

.....
HOME TEL: WORK/MOBILE:

Over

2ND **CONTACT** **NAME:**

.....

ADDRESS:.....

HOME TEL: WORK/MOBILE:
.....

Name and address of family doctor:

NAME: TEL NO:
.....

ADDRESS:
.....

**ALL STUDENTS (INCLUDING THOSE OVER 18)
ARE REQUIRED TO COMPLETE THE ABOVE DETAILS.**

***PLEASE RETURN AS PART OF YOUR TOUR APPLICATION BY
SATURDAY, 5th NOVEMBER***

THIS FORM OR A COPY MUST BE TAKEN BY THE GROUP LEADER ON THE VISIT A COPY SHOULD BE RETAINED BY THE SCHOOL CONTACT

Tour 2012/Parental Consent Form 2012