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| **PARENTAL/GUARDIAN CONSENT FORM** A completed, signed consent form is a condition of participation for those under the age of 18**.** |
| **Please complete this form and return to** **reception@flowerfield.org****This information is necessary should we need to contact you while your child is at Flowerfield.** **The information on this form is considered confidential.** |
| **ATTENDANCE CONSENT FOR UNDER 18:** |
| **Permission is granted for *(full name of child)*:**  |  |
| **To participate in *(name of workshop):*** |  |
| **On *(date of workshop)*:**  | Click or tap to enter a date. |
| **PARENT/GUARDIAN INFORMATION:** |
| **Contact 1** | **Parent/Guardian Name:** |  |
| **Address:** |  |
| **Email:** |  |
| **Phone (Home):** |  |
| **Phone (Work):** |  |
| **Mobile:** |  |
| **Contact 2** | **Parent/Guardian Name:** |  |
| **Address:** |  |
| **Email:** |  |
| **Phone (Home):** |  |
| **Phone (Work):** |  |
| **Mobile:** |  |
| **CONSENT TO PHOTO/VIDEO:** |
| **Do you give permission to the under-18 being photographed/videoed for publicity purposes?** | **YES** [ ]  | **NO** [ ]  |
| **HEALTH INFORMATION:** Please provide the information requested, as it may be needed in case of an emergency. |
| **Date of birth:** |  |
| **Medical card number:** |  |
| **Allergies:** |  |
| **Conditions requiring special consideration (medical/physical):** |  |
| **Does the child require:** | **Epipen****YES** [ ]  **/ NO** [ ]  | **Inhaler****YES** [ ]  **/ NO** [ ]  | **Any medication****YES** [ ]  **/ NO** [ ]  |
| **If yes, provide details:** |  |
| **In the unlikely case of an emergency, it is important to know if she/he can take:** | **Paracetamol****YES** [ ]  **/ NO** [ ]  | **Panadol****YES** [ ]  **/ NO** [ ]  | **Asprin****YES** [ ]  **/ NO** [ ]  |
| **Any other relevant information:** |  |
| In the case of an emergency, we will do everything possible to contact the parents/guardians so that they can make appropriate medical decisions for their child. In extreme circumstances where medical treatment is required without delay and it has been impossible to contact those named on this form, I hereby authorise the certified first-aider/health professional to give any medical treatment on my/our behalf.  |
| **Parent/Guardian Name:**  |  | **Date:** Click or tap to enter a date. |
| **Parent/Guardian Signature:**  |  |