8 November 2019

Dear Parent /Carer

Villiers Park Uni Masterclass – 12/11/19

I am writing to you to inform you of the programme for the Year 10 Villiers Park Uni Masterclass.

Students will need to meet the teacher at the William Parker Upper car park – where the coach will depart.

Year 10 Skills4Success University Masterclass
Tuesday 12th November 2019
Canterbury Christ Church University, CT1 1QU
Departures: Ark Alexandra Academy (Upper School entrance) - 8.10am; Return: Leave Canterbury at 2.30pm and reverse order drops

During the day students will have a tour of the university and explore different areas of the campus. As part of the day they will also get to observe a lecture in subjects that interest them.

Lunch will be provided

Students will need to wear uniform. Students will be dismissed from the venue.

Kind regards

L Fagan / J Poole Year 10 Liaison team
Mrs Iglinski – Villiers Park Lead Teacher
Please complete the attached form and return to Mr Poole by Friday 8 November it is not received by this date your Son/ Daughter will not be given absence permission to attend the masterclass.

Signed
Dated
Parental Consent for an Educational Visit/ Off-site Activity (non-residential)

To be distributed with an Information Sheet giving full details of the visit

1. Details of visit/ activity: Villiers Park Uni Masterclass

Date: _12 NOV  Time: from 8AM to _3:30PM

I agree to my son/daughter __________________________ (full name) taking part in this visit. I have read the information sheet and agree to his/her participation in the activities described and acknowledge the need for him/her to co-operate with staff and to behave responsibly.

2. Medical information about your child

a) Does your child have a condition not already advised to the School which will or might require treatment during the day? (Staff will ensure the continued care of known pupils with special medical needs, as in school)

Yes  No

b) If Yes, please give brief details including special measures such as an injection, means of storing the medication, how often to be taken, etc: (Staff have to be willing and able to administer the medication. Training may be required)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

c) Please outline any special dietary requirements that may have to be considered:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

d) Please state the type of pain control medication that your child may be given, if needed. If you give no indication it will be assumed that no medication can be given unless prescribed by a medical practitioner:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
e) Is your Son/ Daughter allergic to any medication?

Yes  No  I do not know

If Yes, please specify:


(f) Does your Son/ Daughter suffer from any allergic reactions?

Yes  No  I do not know

If Yes, please specify:


(g) Has your Son/ Daughter had a tetanus injection within the last 10 years?

Yes  No  I do not know

3. Contact addresses and telephone numbers

Home:

Address: _____________________________________________________________________
_____________________________________________________________________

Tel Nos: ________________ (home) ________________ (work) ________________ (mobile)

Alternative Emergency Contact:

Name and relationship: _________________________________________________

Address: _____________________________________________________________________
_____________________________________________________________________

Tel Nos: ________________ (home) ________________ (work) ________________ (mobile)

Family Doctor:
4. Declaration

I agree to inform the Party Leader as soon as possible of any changes in the medical or other circumstances of my Son/ Daughter between now and the Visit/ Activity.

I understand that I have responsibility for transportation of my Son/ Daughter to this Visit.

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. I understand that all reasonable efforts will be made to contact me before taking any action but that in particular cases this may not be possible. I also acknowledge the extent and limitations of the insurance cover provided.

I understand that neither the School nor the teacher named above is liable for any claim or claims of whatsoever nature arising during the visit referred to above by virtue of the attendance of my Son/ Daughter except incidents arising from the negligence of the School or its employees.

I warrant that the information given above is correct to the best of my knowledge.

Signed: __________________________________________ Date: _______________________

Full name (block letters): _______________________________________________________

Relationship to the pupil: ______________________________________________________