Name …………………………………………………………………………………………..

Community …………………………………………………………………………………

Booklet of Forms

to be

Completed

and

Returned

2020 – 2021

***Please return intact to SIMS Office***

Some forms (e.g. East Sussex Health Care Plan) may not apply,

in which case please do not complete these.

A copy of this document can be found electronically at:

<http://www.ratton.co.uk/starting-ratton>

**This form is compulsory and must be completed in full by parents/carers.**

**A separate form should be used for each child.**

**CONSENT FORM**

Student Name: …………………………………………. Year Group/Tutor ....……………Community: ……………………………

Please complete this summary consent form in addition to the detailed forms on the following pages by ticking the boxes and signing at the bottom of the page.

1. **Photography and Filming Consent**. We would like to use photographs and videos of your child (as applicable). These images may appear in different forms of media which require your consent and may be used for up to a year after your child leaves the school. Please tick the boxes below to give your consent.

**I give consent for photographs/videos of my child to be used for in/on**

|  |  |  |
| --- | --- | --- |
| **Ratton School/SDLT Website** |  |  |
| **Ratton School/SDLT Newsletter** |  |  |
| **Ratton School/SDLT Internal Displays** |  |  |
| **Ratton School/SDLT Promotional Material (eg Prospectus)** |  |  |
| **Ratton School/SDLT Social Media** |  |  |
| **External Publications (eg Local Press)** |  |  |

1. **Biometric Consent**. For use as part of our cashless school catering recognition system and I understand that I can withdraw consent at any time. Once your child ceases to use the biometric recognition system, his/her biometric information will be securely and permanently deleted by the school.

**I give consent for the biometrics of my child to be used by Ratton School**

1. **Medical Information Consent**. The information in this booklet is for the benefit of your child whilst away on any school trip. Without the information your child will not be able to attend.

**I give consent for medical information of my child to be used by Ratton School**

Name of Parent/Carer: ……………………………………………… Signature: ……………………………………………………………

Date ……………………………………………………………………………..

Where we have asked for consent to use pupil data you can withdraw consent at any time by emailing [dpo@ratton.co.uk](mailto:dpo@ratton.co.uk). It can also be withdrawn through Edulink.

**This form is compulsory and must be completed in full by all parents/carers**

**A separate form should be used for each child**

**This form is compulsory and must be completed in full by all parents/carers**

**A separate form should be used for each child**

**Student Code of Conduct for ICT**

**To ensure that you are fully aware of your responsibilities when using information and communication systems this code of conduct needs to be signed.**

* I understand that it is a criminal offence to use a school ICT system for a purpose not permitted by

its owner.

* I appreciate that ICT includes a wide range of systems, and not just computers.
* I understand that school ICT systems may not be used for private purposes.
* I understand that my use of school ICT systems, internet and email may be monitored and recorded

to ensure policy compliance.

* I will respect system security and I will not disclose any password or security information to anyone

other than an authorised system manager, and I will not attempt to gain access to any user account

other than my own.

* I will not install or attempt to install any software or hardware.
* I will not damage or attempt to damage any school ICT equipment or software.
* I will only use software permitted for student use.
* I will not access or attempt to access any part of a school ICT system that is not intended for

students.

* I will not bypass or attempt to bypass the school internet filter to access websites which have not

been approved for use in-school.

* I will use ICT in class in a manner appropriate to the lesson being taught.

The school may exercise its right to monitor the use of the school’s information systems and internet access, to intercept e-mail and to delete inappropriate materials where it believes unauthorised use of the school’s information system may be taking place, or the system may be being used for criminal purposes or for storing unauthorised or unlawful text, imagery or sound.

I have read, understood and accept the Student Code of Conduct for ICT. I understand that deliberate non­adherence to this Code of Conduct or Acceptable Use guidance may lead to formal disciplinary action.

Signed by student: .......................................................................................................... Number: .....................................................

Name: ................................................................................................................................... Date: ...........................................................

Signed by Parent / Carer :....................................................................................................................................................................

Name: ................................................................................................................................... Date: ...........................................................

RATTON SCHOOL BLACKMEDICAL INFORMATION

AND CONSENT FORM

**PLEASE RETURN TO THE FINANCE OFFICE**

|  |
| --- |
|  |

**YEAR/TUTOR GROUP**

Annual School Trips Form

Annual School Trips Form

Trip/Excursion Title

September 2020 – August 2021

September 2017 – August 2018

Trip/Excursion Date

Ratton School Staff

Ratton School Staff

Organiser

**This form should be completed in full by the parent or carer.**

A separate form should be used for each child.

**PLEASE COMPLETE ALL THE SECTIONS IN BLOCK LETTERS**

|  |  |
| --- | --- |
| Surname (of child) | First Name (of child) |
| ADDRESS | TEL(day) |
|  | (night) |
|  | (work mother) |
| POST CODE | (work father) |
| NAME OF PARENT/CARER | |
| EMERGENCY CONTACT | |
| ADDRESS | TEL (day) |
|  | (night) |
|  | (work) |
| POST CODE | (other) |
| EMERGENCY CONTACT NAME (if different from parent/carer) | |
| DOCTORS NAME | |
| SURGERY ADDRESS | TEL |
|  | |
| NATIONAL HEALTH NUMBER |  |
| DATE OF LAST TETANUS INJECTION |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ANY MEDICAL CONDITIONS (eg. asthma, allergies, diabetes etc.) | | | |
| PRESCRIBED MEDICATION TO BE TAKEN | SHOULD THIS BE ADMINISTERED BY AN ADULT?    YES NO | | |
| ANY FOOD ALLERGIES OR SPECIAL DIETARY REQUIREMENTS?  (eg. vegetarian etc.) | | | |
| My child can swim 50 metres | | | Yes\* No\* |
| My child has permission to swim in the sea | | | Yes\* No\* |
| My child has permission to swim in a public swimming pool | | | Yes\* No\* |
| I certify that I have given all information that is relevant to the wellbeing of my child.  I authorise that emergency medical treatment may be administered by properly qualified persons should this become necessary during the course of my child’s visit.  I authorise that an anaesthetic may be given to my child be it in the United Kingdom or abroad.  I certify that there is no restriction on my child being taken out of the United Kingdom.  **If you are unable to give this authorisation please state the reason in the space provided below.** | | | |
| BIRTH: Town Country Date of Birth  Actual age as of September 2020 ....................................... | | | |
| OTHER RELEVANT INFORMATION  Passport Number:…………………………………………………………………………..  Expiry Date:…………………………………………………………………………………… | | | |
| Signed | | Date: | |

\*Please delete where applicable ...............28th Septemer 2013..................

THE INFORMATION ON THIS FORM IS FOR THE BENEFIT OF YOUR CHILD WHILST AWAY ON ANY SCHOOL TRIP. WITHOUT THE INFORMATION I AM AFRAID YOUR CHILD WILL NOT BE ABLE TO ATTEND.

**Only complete if your child has an ongoing medical condition**

**(Medical evidence must be provided by a medical expert - GP or hospital consultant)**

Appendix B

Health Care Plan

|  |  |
| --- | --- |
| Name of Child: | .............................................................................................................................................. |
| Date of Birth: | ............................................................................................................................................... |
| Address | ................................................................................................................................................. |
|  | ................................................................................................................................................. |
|  | ………………………………………………………………………………………………………………………………………….. |

Medical Diagnosis or Condition: .......................................................................................................... Date: ..................................................................................................................................................... Class/Form: .......................................................................................................................................... Review Date: ........................................................................................................................................

|  |  |  |  |
| --- | --- | --- | --- |
| **Contact Information** | | | |
| **Family Contact 1** | | **Family Contact 2** | |
| Name: | ............................................................... | Name: | .......................................................................... |
| Phone (Work): ................................................................. | | Phone (Work): .......................................................... | |
| (Home): ................................................................ | |  | (Home): .......................................................... |
| Relationship: .................................................................... | | Relationship: .................................................................... | |
| **Clinic/Hospital Contact** ............................................... | | **GP** | .......................................................................... |
| Name: | .............................................................. | Name: | .......................................................................... |
| Tel No: | ............................................................... | Tel No: | ......................................................................... |

Please complete the reverse of this form giving as much detail as possible especially for the section in what constitutes an emergency and action to take

Describe medical needs or condition and give details of pupil’s individual symptoms: ............................................................................................................................................................................................................................................................................................................................................................................................................................................................................................ ..............................................................................................................................................................

Daily care requirements (e.g., before sport/at lunchtime): ............................................................................................................................................................................................................................................................................................................................................................................................................................................................................................. Describe what **constitutes an emergency** for the pupil and the action to take if this occurs: ............................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................

Action to take if this occurs

.................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................... Follow-up Care: .......................................................................................................................................................................................................................................................................................................................................................................................................................................................................................

Who is responsible in an emergency: (state if differ on off-site activities): ..........................................................................................................................................................................................................................................................................................................................

Procedures to be followed when transporting the pupil (e.g. home to school transport, off-site visits):

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

Signed .......................................................................................Signed .......................................................................

(headteacher/manager) (Parent/Carer)

Date ....................................................................................... Date ..............................................................................

OFFICE USE ONLY. Form copied to:

🞏 C&W 🞏 SEN 🞏 General Office

**To be completed by the parent/carer of any child to whom drugs may be administered under the supervision of school staff**

Appendix D Parental Consent Form

|  |  |
| --- | --- |
| Name of Child: | ................................................................................................................................................. |
| Date of Birth: | ................................................................................................................................................. |
| Address | ................................................................................................................................................. |
|  | ................................................................................................................................................. |

Medical Diagnosis / Condition / Illness: ............................................................................................ Date: ..................................................................................................................................................... Class/Form: .......................................................................................................................................... Review Date: ........................................................................................................................................

Doctor’s Telephone Number: ..............................................................................................................

The Doctor has prescribed (as follows) for my child:

a) Regularly:

Name of Drug or Medicine:

How often (e.g.; Lunchtime? After food):

How much (e.g.; Half a teaspoon? 1 tablet?) to be given:

b) In special circumstances: (here describe what circumstances, and the nature

and dosage of the prescribed medication or treatment)

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

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

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

......................................................................................................................................... ………………

**A separate form must be completed for each medicine.**

I accept that I must deliver the medicine personally to (agreed member of staff). The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school/early year’s setting staff administering medicine in accordance with their policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.

I undertake to supply the school with the drugs and medicines in properly labelled containers.

I accept that whilst my child is in the care of the School, the School staff stand in the position of the parent and that the school staff may therefore need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

Signed ....................................................................................................................................

Date ………………………………………………………………………………………………………………………………

**Parental Consent form to be completed if your child needs to carry their own Auto Injector or Asthma Medication/Inhaler**

**Students must not share medication with another student under any circumstances**

Appendix G

This form must be completed by parents/carers

If staff have any concerns, please discuss this request with healthcare professionals.

Name of Child: ............................................................................... Class: ....................................................... Address .................................................................................................................................................................

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

Medical Diagnosis / Condition: .....................................................................................................................

Name of Medicine: ........................................................................................................................................... Procedures to be taken in an emergency: ....................................................................................................................................................................................................................................................................................................................................................................

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

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

Contact Information

Name: …………………………………………………………………..

Daytime Telephone No: ......................................

Relationship to child: ...........................................

I would like: ............................................................ (student name) to keep his/her medication on him/her for use as necessary.

Signed: ......................................................................

Date: ..........................................................................

Relationship to child: ...........................................

A separate form must be completed for each medicine.