

Agreement for Excursions

This excursion has been approved by the Excursions Co-ordinator on behalf of organising establishment

Excursion(s) to \_\_\_\_\_  
Date(s) from \_\_\_\_\_ 20 to \_\_\_\_\_ 20

SECTION A – PARTICIPANT DETAILS

Participant’s Surname \_\_\_\_\_ Forename \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_ Contact Telephone Number(s) \_\_\_\_\_  
Emergency Telephone Number(s) \_\_\_\_\_

SECTION B – MEDICAL AND ADDITIONAL SUPPORT DETAILS (please circle as appropriate)

Name and Address of Family Doctor \_\_\_\_\_  
\_\_\_\_\_ Telephone Number \_\_\_\_\_  
1. Does the participant suffer from:  
a. Any allergies? Yes/No  
b. Travel sickness? Yes/No  
If yes, please give details \_\_\_\_\_  
2. Has the participant received a tetanus injection in the last five years? Yes/No/Don’t Know  
Please give date of last Tetanus injection if known \_\_\_\_\_  
3. If required, do you consent to the following being administered to the participant?:  
a. Pain Relief? Yes/No  
Any brand not permitted? \_\_\_\_\_  
b. Sunscreen protection? Yes/No  
Any brand not permitted? \_\_\_\_\_  
c. Antihistamine? Yes/No  
Any brand not permitted? \_\_\_\_\_

4. Is the participant taking any medication? Yes/No

Does he/she suffer from any medical condition? Yes/No

If so please request an **EE2B form** from the school/establishment and complete and return as soon as possible.

5. Does the participant have any Additional Support Needs, illness, injury or condition which might affect his/her participation? Yes/No

If yes, please give details on a supplementary sheet

**EMERGENCY MEDICAL TREATMENT (THIS MUST BE SIGNED BY PARENT/CARER IF THE PARTICIPANT IS UNDER 18)**

6. I agree to the participant receiving emergency dental, medical or surgical treatment **INCLUDING BLOOD TRANSFUSION**/anaesthetic, as considered necessary by the medical authorities present. I understand that The City of Edinburgh Council has in force a Public Liability Insurance Policy which caters for its activities as a public authority. There is no cover in force for Personal Accident. I understand reasonable attempt will be made to contact parents/carers before administering treatment. Yes/No

If yes, please sign \_\_\_\_\_ **Date:** \_\_\_\_\_

**Any Parents/Carers with objections to the administration of blood products should contact the Head of Establishment for a EE2A Form**

**PLEASE NOTE ANY CHANGE IN MEDICAL CONDITIONS OR MEDICATION MUST BE NOTIFIED TO THE ESTABLISHMENT AS SOON AS POSSIBLE**

**SECTION C – ADDITIONAL INFORMATION (please tick as appropriate)**

1. For water based activities. A non-swimmer  Competent swimmer  Excellent swimmer   
Please tick the appropriate box in relation to the participant's swimming ability

2. Does the participant have any special dietary requirements? Yes  No

If yes, give details \_\_\_\_\_  
\_\_\_\_\_

**SECTION D – PHOTOGRAPHY/VIDEO CONSENT**

**THIS SECTION MUST BE COMPLETED BY A PARENT/CARER IF THE PARTICIPANT IS UNDER 18**

1. It is normal practice to take photographs/video for promotional and funding/evaluation purposes. Should you not wish the participant to be included, please tick this box.

**I agree to the participant taking part in this excursion:**

Date \_\_\_\_\_ Signed by Parent/Carer \_\_\_\_\_

**OFFICE/ORGANISATIONAL USE ONLY:**

Signature of Excursions Co-ordinator

Date