



### **PARENTAL CONSENT FORM**

Please note that a **signed consent form** is a condition of participation in all activities/away trips organised by Fingal County Youth Orchestra for those under the age of 18 years.

I/We \_\_\_\_\_ give permission for my child/children listed below to attend all events/away trips organised by the committee of FCYO.

Names:

Child 1 \_\_\_\_\_ Child 2 \_\_\_\_\_

Child 3 \_\_\_\_\_ Child 4 \_\_\_\_\_

Tick below with a “v = Yes” and an “X= No” for your child/children to be associated with any of the following:

- ☐ Events / activities (home and away) e.g. bonding activity, bowling, performing at outside venues, etc.
- ☐ Photograph of child/children to appear on promotional material
- ☐ To appear on Video/Fingal County Youth Orchestra website
- ☐ Television documentaries
- ☐ Travel on transport, designated as official, for the purpose of an event
- ☐ Personnel who supply/distribute uniforms for Juniors/Seniors may measure your child/children to ascertain correct sizes.
- ☐ Swimming on Away Trips.

#### **Contact Details:**

Father's Name: \_\_\_\_\_ Telephone/Mobile Contact No \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Telephone/Mobile Contact No \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Telephone/Mobile Contact No \_\_\_\_\_

If Parent/Guardian is not available; please **nominate** someone who can be contacted in case of emergency:

Name: \_\_\_\_\_

Relationship to Child/Children: \_\_\_\_\_

Telephone/Mobile No. \_\_\_\_\_

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P.T.O.

## Medical History

**Child 1 : Name** \_\_\_\_\_

Please give details of any **existing medical condition, allergy, medication or dietary needs** which affect or may affect your child. **N.B. It is essential that we are informed of any medication that is being taken even when supervision is not required.**

\_\_\_\_\_

\_\_\_\_\_

**Child 2 : Name** \_\_\_\_\_

Please give details of any **existing medical condition, allergy, medication or dietary needs** which affect or may affect your child. **N.B. It is essential that we are informed of any medication that is being taken even when supervision is not required.**

\_\_\_\_\_

\_\_\_\_\_

**Child 3 : Name** \_\_\_\_\_

Please give details of any **existing medical condition, allergy, medication or dietary needs** which affect or may affect your child. **N.B. It is essential that we are informed of any medication that is being taken even when supervision is not required.**

\_\_\_\_\_

\_\_\_\_\_

### **Medical Permission:**

In the event of an accident/emergency where I cannot be reached, I give my consent to the doctor/surgeon to administer a general anaesthetic and / or appropriate treatment to my child/children (1)\_\_\_\_\_, (2)\_\_\_\_\_,(3)\_\_\_\_\_. All expenses incurred are to be reimbursed by us, the parents/guardians, to Fingal County Youth Orchestra.

**N.B. Both parents/guardians must sign below.**

Father's signature:\_\_\_\_\_ Date : \_\_\_\_\_

Mother's signature:\_\_\_\_\_ Date : \_\_\_\_\_

Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_