



Dear Parents,

As part of our History this term a visit to the Herbert Gallery and Museum, located in Jordan Well, Coventry, has been arranged for Year 1 on the 13<sup>th</sup> October leaving at 9.30am returning for the end of the school day.

The children will be visiting the Walking with Beasts exhibition. This exhibition is based on the BBC TV series of the same name. The exhibition includes the animatronics and models of the animals that were featured in the TV shows. The children will have the opportunity to explore the exhibits, drawing them and finding out more information about the animals. We will also have the opportunity to look around the other galleries in the museum and we are being provided with toys from the past and the present to look at and compare.

The children should wear their school uniform and they will need to be provided with a **packed lunch in a plastic bag**, which can be thrown away. The cost of the trip, £10, will be added to your fees.

Please complete the slip at the bottom of this letter and the medical form and return it to me as soon as possible.

Please do not hesitate to contact us if you have any queries.

Yours sincerely

Miss Rayner and Mrs Alexander

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### Visit to Herbert Gallery and Museum – 13 October 2011

I give/do not give\* permission for \_\_\_\_\_ (Child's Name)  
\_\_\_\_ (Class) to go to the Herbert Gallery and Museum and for the cost of £10 to be added to my account.

Signed \_\_\_\_\_

Print \_\_\_\_\_

**PARENTAL CONSENT FOR A SCHOOL VISIT**

**1. Details of the Visit to:     Herbert Gallery & Museum**

From: Date/Time:..... To: Date/Time: .....

I agree to : ..... (Name)  
taking part in the visit and have read the information sheet. I agree

to .....’s participation in the activities described. I

acknowledge the need for ..... to behave responsibly.

**2. Medical information about your child:**

a) Any conditions requiring medical treatment, including medication?     YES/NO

    If YES, please give brief details:

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b) Please outline any special dietary requirements of your child and the type of pain/flu relief medication your child may be given if necessary:

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**For residential visits and exchanges only:**

c) To the best of your knowledge, has your son/daughter been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be contagious or infectious?

YES/NO

    If YES, please give brief details:

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d) Is your son/daughter allergic to any medication? YES/NO  
If YES, please specify:

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e) When did your son/daughter last have a tetanus injection?

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I will inform the Group Leader/Head Teacher as soon as possible of any changes in the medical or other circumstances between now and the commencement of the journey.

**3. Declaration:**

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 whilst the leaders will take all reasonable care they cannot be held responsible for any loss, damage or injury to anyone taking part.

I understand the extent and limitations of the insurance cover provided.

Contact Telephone numbers:

Work: \_\_\_\_\_ Home: \_\_\_\_\_

Home address: \_\_\_\_\_

\_\_\_\_\_

Alternative emergency contact:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Name of family Doctor: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Signed : \_\_\_\_\_ Date: \_\_\_\_\_

Full Name (Block Capitals: \_\_\_\_\_

**THIS FORM OR A COPY MUST BE TAKEN BY THE GROUP LEADER ON THE VISIT. A COPY SHOULD BE RETAINED BY THE SCHOOL CONTACT.**

