



FORM OV 7B (CSF4259)

**SELF-CONSENT FORM FOR ADULTS
(or young people living independently)**

Establishment: Bonneygrove Primary School

To be completed by visit leader/organiser

| | | |
|--|-----------------------------------|--|
| Visit: | Kingfisher Nursing Home | |
| Visit Leader: | Miss Morris | |
| Date of Visit: | From: 22 nd April 2026 | |
| Is a photograph of participant required: | Yes / No | |

To be completed by participant.

(May be completed and signed digitally i.e. with an email address or scanned manuscript signature)

| | |
|---|----------------|
| Full name: | Date of Birth: |
| Do you: <ul style="list-style-type: none"> • Have a medical condition requiring medical treatment or medication? Y/N • Have an allergy to certain medications? Y/N Please give details of medical condition/treatments or allergies to medications below: | |
| Have you been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may become contagious or infectious? If yes, give details: | Y/N |
| Have you supplied details of your Inoculations record with this form? | Y/N |
| Do you have any special dietary requirements? If yes, give details: | Y/N |
| I wish to draw the following to the Visit Leader's attention (e.g. allergies, phobias, recent operations and treatments, conditions which may affect fitness to participate in certain activities): | |
| | |

EMERGENCY CONTACT INFORMATION

| | | |
|--|-------------|--------------------|
| Name: Relationship: Address: Telephone Numbers: Day: Evening: Other: | MAIN | ALTERNATIVE |
|--|-------------|--------------------|

| |
|--|
| FAMILY DOCTOR DETAILS |
| Name: Address: Telephone Numbers: NHS Number (if known) |

| | |
|---|-------|
| DECLARATION I have received and understood the details of the visit. I confirm that I am in good health and fit to participate in the activities described. I agree to receive medical treatment as considered necessary by the medical authorities present. I undertake to inform the visit organiser as soon as possible of any change in medical circumstances between the date signed and the commencement of the event. | |
| Signed: | Date: |
| Name in Capitals: | |
| Address: | |
| Postcode: | |
| Telephone No: | |
| Permission for use of image (optional) I do / do not* (<i>*delete as applicable</i>) give my permission for my image to be taken for use in educational or youth work promotional materials and displays when required, with or without using my name. | |
| Signed: | Date: |
| Where required, a passport sized photograph has been attached / provided (Yes / No / Not required) | |

**The information on this form should be retained by the establishment's emergency contact.
This form or a copy may be taken by the visit leader on visits outside the UK**