**PARENTAL CONSENT FORM SPY Network**

Website: bodminchurch.com/young-people facebook.com/BodminWay Contact: info@bodminway.org

SPY is usually a monthly event on **Sundays**, **3pm to 4pm**, St Petroc’s Parish Centre. It’s a get together for those aged **9+** in a safe and friendly environment. Activities include team games, drama, song, crafts, games in Priory Park and short walks. Our safeguarding office can be contacted via *safeguarding@bodminway.org**,* “*Ensuring young people as well as adults are kept safe while in our care is an integral part of Bodmin Way’s life. For more information visit bodminway.org/safeguarding.”* It’s **FREE** to attend. We expect attendees to show respect to all young people, leaders, resources and building, so that they can continue to come along.

Either print and complete for the young person to bring to SPY or fill in online and email to info@bodminway.org

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| Name of young person: | Date of birth of young person:  |
| Name of parent/carer: | Phone of parent/carer: |
| Home address of young person: | Email of parent/carer:Facebook address: |
| Name of emergency contact: | Phone of emergency contact: |
| Doctor and surgery: | Phone of surgery (if known): |
| Medical issues: *Continue on separate sheet if necessary* | Medicines used: |
| Allergies – Food: | Other allergies: |
| Anything else we should know? | Are you happy for your young person to walk home on their own or with others? [ ]Will you always collect? [ ]Is there anyone who is not permitted to collect? |
| I consent to my young person’s image being taken and used to record/promote SPY, on social media and website or shared with funders. Young people will **not** be identified by name. **Yes: No:** Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ |
| My young person named above is in good health and capable of the activities (or most). I agree to them taking part **inside and outside** the Parish Centre. In event of an accident l consent to medical treatment or/and l consent to treatment by medical health professionals if deemed necessary.Signature of parent/guardian/carer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of parent/guardian/carer (PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |