****



**PARTICIPANT PERMISSION FORMS**

Welcome to First Star.

This pack contains important permission forms that **must be signed and returned** in order for the participant to attend the planned Programme events.

We look forward to a rewarding open day with you!

|  |
| --- |
| ***Confirmation all sections signed – To be completed by First Star Staff******Name of Director:***  |
| ***Signature of Director:*** |
| ***Date:***  |
| ***Name of participant:***  |

# Consent Form

I hereby acknowledge that (insert name & Date of Birth of participant) ………………. has been given permission by their carer (insert name of carer) ………………………….to participate in the First Star Scholars Programme at (insert name of university) ………………………. from herein. I agree and understand that:

1. I will communicate immediately with the Programme staff members if there are any significant events or changes in the participant’s life that may inhibit our ability to support the participation (e.g., positive covid test).
2. In the event of an accident, misadventure, or illness whilst away from home, I give consent for a qualified medical practitioner to administer any necessary medical treatment.
3. I will encourage the participant to cooperate with the Programme staff and to follow all Programme expectations. Participants may need to leave the Programme in extreme cases of illness or breach of Programme and University rules. In such circumstances I will be responsible for promptly making arrangements to retrieve the participant as directed by the Director.
4. I understand that the participant is responsible for his/her own belongings. The First Star Programme will not be held responsible or make insurance claims for any item(s) lost, stolen or damaged.
5. I understand that outside of the classroom, activities may include such things as climbing, sport, and water activities. Therefore, I confirm that the participant is in good health and I consider him/her fit to participate.
6. To ensure the privacy and safety of all participants during the First Star Programme I accept the participant must not take any photographs of any other participant and must not post photos or personal information of peers or staff on any social media account.
7. I understand First Star and/or the university may invite the participant to take part in research (interviews and surveys) or in a video (post 16 years only). I understand that these may be published for marketing and research purposes. I understand I have the right to refuse permission for the participant to take part in or to withdraw the participant from any research activity at any time and to refuse permission for the participant to take part in any video requests.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print Name of Carer Carer Signature

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Date

|  |
| --- |
| **2. Personal Details (Carer)**Name of Carer: Address: Postcode: Home Phone: Mobile: Work Phone:Email:  |

Please confirm that you have informed your child’s social worker that (insert name of participant)………………… is attending First Star programme.

Please confirm the name and contact details of your child’s social worker:

Name.................................................... Email address:............................................................

Contact number...........................................

Name of school your child attends………………………………………………………………….

Signature of carer …………………………………….. Date ………………………………………..

|  |
| --- |
| **4. Emergency contact** I authorise the persons below to pick up and/or liaise with the director in supporting the participant in case of an emergency:  |
| **Emergency Contact #1** (Other than carer) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to the participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **Participant permisssions** I (insert name of participant)………………….…….confirm that I know the emergency contacts provided by my carer and that I am aware they may collect me / provide support in the absence of my carer |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Print Name of Carer Participant Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Carer Date |

|  |
| --- |
| FIRST STAR SCHOLARS PROGRAMME Medical Information Form and Attachments  |

**Medical History**

**Medical Information:**

In the participant’s interest, it is vitally important that the organising staff should be aware of any illness or disability which may affect scholars’s participation and any special dietary needs and medication.

When a medical practitioner has prescribed medication (including emergency medication) that will need to be administered during the programme, carers are responsible for:

* + Bringing this need to the attention of the director/programme
	+ Ensuring that the information is updated if it changes
	+ Supplying the medication and any 'consumables' necessary for its administration in a timely way. The medication should be well within its expiry date.
	+ Collaborating with the First Star Programme in working out arrangements for the supply and administration of the prescribed medication for the duration of the Residential. You may be asked to supply an additional adrenaline autoinjector (i.e. EpiPen® /Anapen ®) for example.

**Has the participant had any of the following?** (please tick if yes)

|  |  |  |  |
| --- | --- | --- | --- |
| Asthma or bronchitis   |  | Allergies to any known medication  |  |
| Heart condition  |  | Travel sickness  |  |
| Seizures, fainting or blackouts  |  | Regular medication  |  |
| Severe headaches  |  | Depression/anxiety  |  |
| Diabetes  |  | Learning disability  |  |
| Panic attacks  |  | Other illness  |  |

If you have answered yes to any of the above, please provide details below:

|  |  |  |
| --- | --- | --- |
| If it is considered necessary, do you agree to mild painkillers (eg: Paracetamol) being administered  | **YES** | **NO** |
| **In addition**  |  |  |
| Does the participant have any known plaster allergies | **YES** | **NO** |
| Is the participant receiving or expecting to receive medical or surgical treatment of any kind from their doctor or hospital?  | **YES** | **NO** |
| Is the participant receiving or expecting to receive dental treatment of any kind from their dentist or hospital? | **YES** | **NO** |
| Has the participant been given specific medical advice to follow in emergencies? | **YES** | **NO** |

If the answer to any of these questions is Yes, please give details here (including name and dosage of any medicines/tablets):

**Allergies and intolerances**

***Please provide detailed information describing the dietary restrictions due to allergies and/or intolerances, for the participant.***

List all allergies/intolerances to medications, food, insect bites, environmental factors, etc: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Other special dietary needs or restrictions (i.e Halal, gluten free, Vegetarian etc.) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**It is very important that we are aware of any allergies that may result in anaphylactic shock.**

Has your child been prescribed an EpiPen for possible anaphylaxis?

**Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_**

**Prescription Medication Authorisation**

**Guardians/carers must complete the attached Prescription Medication Authorisation form and provide all prescription medications that must be administered while attending the Programme.**

**To be completed by carer.** All prescription medications MUST be provided in their original containers with prescriptions and packaging in English.

Participant name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please attach pages to list additional medications or to provide detailed comments.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, carer of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorise the University of Winchester First Star Scholars Programme to administer prescription medications, which I will provide to the Programme, as set forth below to the participant, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Carer Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please include a seperate sheet for each medication:**

* Name of medication(s)
* Condition(s) for which medication is prescribed
* Dosage
* Time(s) of Administration
* Taken prior/post food
* Special Notes
* Who can administer the medication (please inform us which medication requires suitable trained staff)
* Dated Signature of Carer/Guardian giving permission for administration of medicine

**Medication sheet : name of Participant (use separate sheet for each medication)**

|  |
| --- |
| **Name of medication** |
|  |
| **Condition(s) for which medication is prescribed** |
|  |
| **Dosage** |
|  |
| **Time(s) of Administration** |
|  |
| **Taken prior/post food** |
|  |
| **Special Notes** |
|  |
| **Who can administer the medication (please inform us which medication requires suitable trained staff** |
|  |
| **Name and contact details of prescribing doctor**  |
|  |
| **Dated Signature of Carer/Guardian giving permission for administration of medicine** |
| Signature Date  |

**Authorisation for Participant Medication**

**Self-Administration with Adult Supervision**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, **(Carer Name)**  **(Relationship the participant)** give permission for the First Star Programme to supervise and record daily, weekly, or as needed medication self-administration for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Participant Name)**  as prescribed by assigned personnel or carer while in attendance at the residential Programme at University of Winchester. I understand that the Programme staff members are responsible for providing first aid and for safeguarding prescription medication in compliance with local regulations and as authorised by signatures on the appropriate medical forms.

Participants will administer their own medicine, which will be kept by the Director in a secure location. Medicine must be taken according to the instructions on the label and in view of Programme staff.

Participants who need immediate treatment will be taken directly to walk-in clinics or A&E. When participants are referred to local providers, a Programme staff member will accompany them, and inform the carer as soon as possible.

In the event of a participant attending A & E, social services will automatically be informed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Carer Signature)** **(Date)**

**FINAL DECLARATION**

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(insert carer’s name*) carer of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*insert participant’s name*) confirm that I have read and understood the information in this pack and have filled out all sections accurately with up to date details.**

 **Carer signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed \_\_\_\_\_\_\_**