**CONFIDENTIAL**

 **PARENTAL CONSENT & SPECIAL MEDICAL NEEDS FORM**

**FOR YOUNG VOLUNTEERS (Under 18)**

**Name of volunteer** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Volunteering role title**……………………………………………………………

**Organisation……………………………………………………………………..**

Please complete the form below to indicate whether your child has any medical needs which you feel **may affect their volunteering placement.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| Physical disabilities  |  |  | Diabetes/Epilepsy/Asthma |  |  |
| Learning difficulties |  |  | Other  |  |  |
| Allergies  |  |  | Regular medication |  |  |

**If you have answered YES to any of the above, please give further details particularly any restrictions or means of managing the situation advised by a doctor or any other specialist:**

If the answer is ‘Yes’ to any of the questions above, the information will be shared with anyone supporting the volunteer to ensure that they have appropriate supervision.

**Any other concerns you would wish brought to our attention:**

**I understand the type of volunteering that my child is taking part in and any associated risks. I understand that it is ultimately my responsibility to decide the suitability of the opportunity for my child.**

**I am willing for my son/daughter to participate in volunteering and will do what I can to support them to participate.**

**Signature of Parent/Guardian** …………………………………………………………………………**Date**………………………………….

**Print name: …………………………………………………………………**

**[Insert appropriate data protection statement here]**