

Medical Consent Form

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE THE ACTIVITY

Full Name:	Date of Birth:
Address:	
Telephone No (incl. code):	
Emergency Contact Name:	Relationship:
Emergency Contact Address (during event):	
Telephone No (incl. code):	
PERMISSION TO TAKE PART (To be completed by parent/guardian)	
I hereby agree to my Son / Daughter taking part in (Name of activity):	Signature:
	Dated:

MEDICAL INFORMATION (To be completed by parent/guardian)		
Doctors Name:		
Doctors Address:		
Telephone No (day) (Incl. code):	Telephone No (night) (Incl. code):	
HEALTH INFORMATION (It is important to complete this as fully as possible)		
	* delete as necessary	Give details to "yes" answer.
Are there any medical or health reasons why they should not take part in the activity?	*NO/YES	
Has he / she been in contact with any infectious illness in the last 6 months?	*NO/YES	
Does he / she suffer from ASTHMA, HAYFEVER, MIGRAINE, FITS, FAINTS, EPILEPSY, DIABETES, or any other ILLNESS or DISABILITY?	*NO/YES	
Is he / she taking any form of regular medication?	*NO/YES	
Is she / he allergic to ANTIBIOTICS, PLASTERS or any other MEDICINES or FOOD?	*NO/YES	
Are there any special DIETARY needs?	*NO/YES	
Date of their last ANTI-TETANUS injection (if known).		
Should the necessity arise, and I cannot be contacted by telephone or any other practical means to authorise urgent medical treatment to the above named, I hereby give my general consent to the Leader in charge to authorise the medical authorities to give any necessary medical treatment.		Signature:
		Dated:

INSURANCE (To be completed by parent/guardian)	
I understand that the above named will need their own Insurance Cover against damage or loss of personal effects.	Signature:
	Dated: