NAME OF EVENT: .....

DATE OF EVENT: .....

MEDICAL CONSENT FORM

PLEASE COMPLETE THE FORM, SIGN AND RETURN TO THE PERSON NAMED BELOW AS SOON AS POSSIBLE.

FAILURE TO RETURN THE FORM WILL MEAN THAT WE CANNOT TAKE THE PARTICIPANT ON THE ACTIVITY.

NAME OF PARTICIPANT:

National Health Service Medical Number:

Date of Birth:

Medical Conditions eg asthma, diabetes, hay fever, allergies or disabilities

Prescribed medicines (eg tablets, insulin)

Recent inoculations:

Special dietary needs (eg vegetarian, food allergies)

In case of emergency:
Name of next of kin: .....

Address where next of kin will be during the activity: .....

.....

Telephone: ..... Mobile: .....

I give my consent to any medical treatment that may be necessary in the event of an emergency during the course of the activity.

Signature of person with parental responsibility:.....

Date:.....

Name, address & contact details of leader
to whom any queries should be addressed