Medical consent and emergency contact form

Revised Mar 09

THIS FORM IS DOUBLE SIDED – PLEASE ENSURE YOU TURN OVER
Please complete all sections in Block Capitals

SAILOR DETAILS:

Sailor Name:	
Home Address:	
Date of birth:	
Age:	

EMERGENCY CONTACTS:

Emergency Contact

Name:	
Relationship:	
Home Number	
Work Number	
Mobile Number:	

Alternative Emergency Contact:

Name:	
Relationship:	
Home Number	
Work Number	
Mobile Number:	

IF DIFFERENT FROM ABOVE:

Mother's Name:		Mobile Number:	
Home Number		Work Number:	
Father's Name:		Mobile Number:	

Home Number		Work Number:	

DOCTOR DETAILS:

Doctors Name:		Surgery Number:	

It is your responsibility to make known any potential medical conditions that may affect you during the activities associated with the programme you will be taking part in. Please therefore provide as many details as possible. This information will be shared with the organisers and coaches at events and training.

Have you ever suffered from any of the following conditions:

- Asthma/bronchitis Yes No
- Heart conditions Yes No
- Fits, fainting or blackouts Yes No
- Severe headaches Yes No
- Diabetes Yes No
- Travel sickness Yes No
- Allergies to medication Yes No
- Any other allergies Yes No
- Other illnesses or disabilities Yes No

If you have answered yes to any of the above, please provide details in the box below.

When did you last have a tetanus vaccination? Year ……

Are you currently taking any medication? If so please specify:

Are you suffering/recovering from any injuries which may affect your sailing?

Are you vegetarian? Yes No Do you have any food allergies? If so, please specify:

Consent

I the parent/guardian of …… give permission to the organisers of activities during the period
..... (dates of event) to administer any relevant treatment or medication to the above-named participant when or if necessary.

In an emergency situation I authorise the organisers to take my son/daughter to hospital and give my full permission for any treatment required to be carried out in accordance with the hospital's diagnosis. I understand that I shall be notified, as soon as possible, of the hospital visit and any treatment given by the hospital.

Signed: …… (parent/guardian)

Name: (please print) ……..

Date: ……