

**Medical Consent and Emergency contact form**

Please complete all sections in Block Capitals

**SAILOR DETAILS:**

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

**EMERGENCY CONTACTS:**

Name:	
Relationship:	
Home Number:	
Work Number:	
Mobile Number:	

**ALTERNATIVE EMERGENCY CONTACTS:**

Name:	
Relationship:	
Home Number:	
Work Number:	
Mobile Number:	

**IF DIFFERENT FROM ABOVE:**

Mother's name:		Father's name:	
Home number:		Home number:	
Mobile number:		Mobile number:	

**DOCTOR'S DETAILS:**

Doctor's name:		Work number:	
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It is your responsibility to make known any potential medical conditions that may affect your child during the activities associated with the programme they 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 authorize 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: .....