

**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