

Name	Age	Male/Fem	DOB
1.			
2.			
3.			

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone (Home): \_\_\_\_\_

Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

**Medical History Information:** (Details of any known allergies, conditions etc.)

\_\_\_\_\_

\_\_\_\_\_

**Other Information:** (Any other special needs, requirements or directions that our leaders should know)

\_\_\_\_\_

\_\_\_\_\_

### **Parental / Guardian Consent**

Medical treatment: In the event of illness, having parental responsibility, I give permission for medical treatment to be administered where considered necessary by a nominated first aider, or by suitably qualified medical practitioners. If I cannot be contacted, and my child needs emergency hospital treatment, I authorise a qualified medical practitioner to provide emergency treatment or medication. I understand that photographs will be taken during the programme and may be used in the promotion of the programme. I hereby consent to the above child(ren) participating in activities of the organisation in line with the Code of Ethics for Young People. I will inform the leaders of any changes to the information above. I confirm that all details are correct and I am able to give parental consent for my child(ren) to participate in all activities.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_