Consent Form & Medical Information

Date of Visit ……..…….……..……..

Name of School……..……..…….……..

DETAILS OF PARTICIPANT (BLOCK LETTERS PLEASE)

Surname…….. Forenames……..

DoB……..…

Home Tel. No…… Email……..

Home Address……

Post Code ……. Nationality…….. Occupation……..

Male / Female (please circle) Height …… Weight ……

Shoe size…….. Waist size …….

Able to swim 50 metres in light clothing ? Yes / No (please circle)

IMPORTANT CONTACTS

	Person we can contact in an emergency.	2nd Contact (if necessary)	Your Doctor
Name & Relationship to participant	……..…… ……..……	……..…..….. ……..…..	
Address	…… …… ……	……..… …… ……..	……..… …… ……..……
Tel			

MEDICAL DETAILS

The information provided on this form will be treated as CONFIDENTIAL and is only required in order to enable Auchengillan to provide appropriate medical help and support if required.

Please answer the questions fully and honestly, if at the start of the visit it is found that the information has not been given correctly, Auchengillan reserves the right to refuse participation.

Where concern exists about physical suitability for the visit, please seek advice from a doctor and obtain their written confirmation that it is appropriate for participation.

	Has the participant ever had:	**Yes / No**	**Important :** If you answer "yes", give details including dates below (use continuation sheet if necessary).
1	Heart trouble, angina, raised blood pressure?	Y / N	
2	Asthma, Bronchitis, tuberculosis or other lung conditions.	Y / N	
3	Diabetes?	Y / N	
4	Epilepsy, fainting attacks, migraine severe head injury?	Y / N	
5	Nervous illness, depression or other psychiatric condition?	Y / N	
6	Allergy to foods (e.g. nuts, dairy produce etc)	Y / N	
7	Other allergic reaction (e.g. hay fever reaction to insect bites or medication?)	Y / N	
8	History of broken bones, muscle tears or Tendon / ligament damage?.	Y / N	
9	Stomach, digestive, abdominal problems?	Y / N	
10	Blood disorders?	Y / N	
11	Bladder, urinary problems?	Y / N	
12	Hearing, visual impairments?	Y / N	
13	A tetanus injection? If so state most recent.	Y / N	
14	Are you suffering from or are you a carrier of any infectious diseases?	Y / N	
15	Have you been treated by a doctor or in hospital in the last two years?	Y / N	
16	Are you taking any medication? If so please state the condition being treated, name the medication, state the dosage and ensure you bring enough.	Y / N	
17	Do you have any special dietary requirements e.g. vegetarian, vegan or Halal?	Y / N	
18	Do you have or suffer from any other diagnosed condition?	Y / N	

IF THERE ARE ANY CHANGES TO THE ABOVE, YOU MUST INFORM AUCHENGILLAN CENTRE IMMEDIATELY.

I DECLARE THAT ALL MEDICAL & ENROLMENT INFORMATION ON THIS FORM IS TRUE AND THAT I HAVE NOT WITHHELD ANY RELEVANT INFORMATION.

In signing for a participant who is under 18 years of age, you endorse the following statement:

"I consent for the above named person participating in the visit stated on this form and I consent to him / her taking part in all activities. I have ensured his / her willingness to participate in all aspects of the visit. In the event of an emergency and Auchengillan being unable to contact me, I give permission for any medical treatment deemed necessary, to ensure the well-being of the above named, to take place".

Signature..... **Print name** ……

(* State relationship to participant……..)