**PARENTAL MEDICAL CONSENT FORM (FOR UNDER 18s)**

**(Under 18’s form is to be completed by Parent or Guardian)**

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Surname: Forename:

Date of Birth: Age:

Address:

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**A. Does this person have any current medical conditions or health issues, or take any regular or ‘when required’ medication? YES/NO**

If YES, please give relevant details:

**B.Has this person had any other health issues in the past?YES/NO**

Include significant surgery and medical conditions.

If YES, please give relevant details:

***Please make sure that he/she is carrying enough medication for the duration of the visit.  For inhaler users, please ensure that there is sufficient supply on the day.***

**C.Has this person ever had any psychological or mental health issues? Eg panic attacks, anxiety, depression, OCD, self-harm, eating disorders or any involvement with**

**CAMHS (Child and Adolescent Mental Health Services).**  **YES/NO**

If YES, please give details:

**D.Does this person have any allergies?YES/NO**

(eg Penicillin, Gluten, Diary, Wheat, Nuts, Paracetamol, Aspirin, etc.)

If YES, please give details including the reaction suffered and any treatment required.

**E.  If necessary, do you give permission for this person to be given (delete as appropriate)**

Paracetamol, travel sickness tablets, ibuprofen, antihistamine cream (for bites),

throat lozenges**YES/NO**

**F.Does this person have a disability that you feel we should be aware of?YES/NO**

If YES, please give details:

**G.To the best of your knowledge, has this person suffered from or been in contact with any contagious or infectious diseases in the last four weeks?YES/NO**

If YES, please give details below.

**H.When did he/she last have a tetanus injection?**

1. **Are there any other personal details that you feel the leader should be**

**aware of?**(Please include fears or phobias, as this will assist staff should a situation arise)

**YES/NO**

If YES, please give details:

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**First named person: Second named person:**

Name: Name:

Relationship to young person: Relationship to young person:

Telephone numbers: Telephone numbers:

Work: Work:

Mobile: Mobile:

Home: Home:

Address: Address:

Name of Family Doctor : Telephone:

Address:

**I would like (name of child)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_to take part in the event and I agree to him/her taking part in the activities described.**

**I confirm that my son/daughter is in good health and I consider him/her to be fit to**

**participate.YES/NO**

**I understand the need for him/her to behave responsibly.**

**I understand that group/activity photographs may be taken during the event in line with the Church’s policy.  I give my consent to this.**

**I am happy for this information to be shared amongst those who will be responsible for this person during the time of the event.**

**In the event of significant past medical history, I am happy for this form to be passed onto the Medical Team who may need to seek further information from me.**

**In the event of an illness or accident, every effort will be made by the event leader or their assistant to contact me.  If for any reason this is not possible:**

**I agree to my son/daughter receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.**

**Signed:(Parent/ Guardian)**

**Print Name: Date:**