



## Consent Form for Juniors making visits away from home

Visit to:.....

Details of trip e.g. distance, grade, hazards

.....  
.....  
.....

Dates:.....

It may be necessary for the adult accompanying your child to have the necessary authority to obtain any urgent treatment which may be required whilst away from home. Would you therefore please complete the details on this page and sign below to give your consent.

Junior's Name .....

Date of Birth .....

Address

.....  
.....

Post Code.....

Telephone Number

.....

Alternative Emergency Contact address (other than parent's or carer's)

Name.....

Relationship to Junior .....

Address.....

.....

Post Code.....

Telephone Number .....

- I have had the activities of the trip explained and agree to my son/daughter ..... taking part in these activities.
- I confirm to the best of my knowledge that my son/daughter does not suffer from any medical condition other than those listed.
- I agree to my child's image being displayed on the club web site **yes/no** (delete)
- I agree to be at the pick up / drop off point at the agreed time.
- I understand that the Organisers accept no responsibility for loss, damage, or injury caused by or during attendance on any of the organised activities, except where such loss, damage or injury can be shown to be the result directly from the negligence of the Organisers.

I ..... being the parent / carer of the above named Junior hereby give permission for the Adult accompanying him / her to give the



immediate necessary authority on my behalf for any medical or surgical treatment recommended by competent medical authorities, where it would be contrary to my son's / daughter's interest, in the doctor's medical opinion, for any delay to be incurred by seeking my personal consent.

Signature ..... (Consent by parent / carer)

Print Full Name .....

Date .....

**Medical information:**

1. Any specific medical information requiring medical treatment and / or medication Yes / No  
If Yes give details including names of medication and frequency of dosage:

2. Any allergies Yes / No  
If Yes give details and treatment required

3. Any contact with infectious diseases in the past four weeks Yes / No  
If Yes give details

.....  
.....

4. Please detail any special dietary requirements.

5. Please detail type of pain / flu relief medication that may be given if necessary:



**DATA PROTECTION**

Any information given will be treated as confidential and shall be accessible only by committee members. These records will be held on file for one year.