

Forename(s)	Surname
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## Details of Event or Group, with date period to be covered

This form must be completed for every person attending the Activity who is under age 18. (Any person under 18 years old must have the signed permission of their parent/ guardian – noted at the end of the first page). We suggest if the activity involves an overnight stay then all should complete one irrespective of age. Where no overnight stay – we suggest those leading the group activity should decide if this is required for adults.

### The small print

All activities will be run in accordance with the authority of the Parochial Church Council of Westbury-on-Trym and associated risk assessments. This data will be held for 50 years if it relates to a person under the age of 18 or for the duration of Church membership and will be disposed of in a secure and responsible manner, when the time arises. Please indicate here that you give permission for all data provided here to be used for the purpose of general Church communications, and that it may be shared with others within the Church for that purpose. Yes

Photographs and video images may be taken during the Activity, and these may include you/ your child. These images will be used, in accordance with the Parish of Westbury-on-Trym Safeguarding Children, Young People and Vulnerable Adults Policy and procedure, possible articles for the local paper or for insert onto our website, or in other ways to promote Church activities.

No responsibility for personal equipment / clothing and effects can be accepted by the Activity organisers and the Church does not provide automatic cover in respect of such items. I understand that the activity Leader reserves the right to send, at the parent's expense any participants home if he deems necessary with no fee refund. This form will be copied once for the home contact. Both copies will be destroyed after the completion of **ALL** Activities, where medical aid has been sought, this document will be kept on file until all matters are resolved.

### Personal details

My / child's date of birth	I / my child has the following special dietary requirements																				
Age																					
My / child's gender      Female      Male																					
My / child's national health number																					
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> <td style="width:5%; height: 15px;"></td> </tr> </table>																					
Religion																					

Other useful information you think we should know about you / my child (ie any special needs)

### Contact details

My / child's doctor's name \_\_\_\_\_  
Practice \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_

My / child's home address \_\_\_\_\_  
\_\_\_\_\_

Postcode \_\_\_\_\_

Telephone daytime \_\_\_\_\_ Telephone evening \_\_\_\_\_  
E-Mail contact \_\_\_\_\_

Mobile (Next of Kin, please include name) \_\_\_\_\_

Signature		Leader use only
Signed Name _____	Self / Relationship to child _____ Date _____	

**This Permission / Medical form must be returned prior to the event attended**



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**Event or Group, with date period to be covered**



**The small print**

I will list below any medicines, treatments to be taken during the activity and the appropriate hospital or specialist concerned if under any treatment. I will also ensure that any medicines required during the activity are handed to the person responsible for first aid before the start of the activity. All prescription medicines must be in their original containers, as issued by the doctor/pharmacist, with the dosage and the name of the recipient clearly shown.

I agree to allow the person responsible for first aid to administer any reasonable 'off the shelf' medical remedied as necessary. All treatment will be recorded on this form.

If it becomes necessary for myself/ my child to receive medical treatment and Next of Kin be contacted by telephone or any other means to authorise this, I hereby give my general consent\*<sup>1</sup> to any necessary medical treatment and authorise the Leader in charge of the Activity to sign any documents required by the hospital authorities.

**Note:** \*<sup>1</sup> The medical profession takes the view that the parent's consent to medical treatment cannot be delegated. This view is explicit in the Children Act 1989. Thus medical consent forms have no legal status and a doctor/nurse insisting on the consent of a parent to a particular treatment has the right to do so. However, it can be a comfort to the medical staff that the general consent in advance from parents has been given or to have a Leader on hand able to sign forms required by medical authorities.

**Medical details**

I/ My child has the following allergies/sensitivities	I/ My child is currently taking the following medicines												
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">Asthma</td> <td style="width:15%;">Yes</td> <td style="width:15%;">No</td> </tr> <tr> <td>Hay fever</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Penicillin</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Plasters</td> <td>Yes</td> <td>No</td> </tr> </table>	Asthma	Yes	No	Hay fever	Yes	No	Penicillin	Yes	No	Plasters	Yes	No	
Asthma	Yes	No											
Hay fever	Yes	No											
Penicillin	Yes	No											
Plasters	Yes	No											
Other medical allergies/sensitivities													
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">Immunised against tetanus</td> <td style="width:15%;">Yes</td> <td style="width:15%;">No</td> </tr> </table>	Immunised against tetanus	Yes	No										
Immunised against tetanus	Yes	No											
Date of last injection													

**First aid & Treatment chart**

**This form is to be filled in upon every visit to the first aider, even if no treatment is given**

Date	Time	Signs & symptoms	
Treatment given			Signed
Date	Time	Signs & symptoms	
Treatment given			Signed
Date	Time	Signs & symptoms	
Treatment given			Signed
Date	Time	Signs & symptoms	
Treatment given			Signed