

CONSENT & MEDICAL FORM FOR CAMPING
TRIP TO NEW FOREST
12th JUNE – 14th JUNE 2009

PLEASE READ THE FOLLOWING CAREFULLY, COMPLETE & SIGN BELOW

Name of child:.....D.O.B.....

I confirm that I am the person who has parental responsibility for the child named above. I have read the information relating to the trip, and my child is aware of the details. I believe that my child is fit to take part in the activities and have declared any relevant dietary requirements and medical details on the form below.

I give consent for the Youth Group Leaders to seek medical advice should illness or an accident occur. If a surgical operation or injection becomes necessary, I authorise the Group Leader in charge to sign on my behalf any written consent to operate, as advised by the medical authorities. I also consent to my child being administered a non-prescription painkiller, antihistamine, sun cream or preventative bug cream by a member of staff if he/she requests.

I agree to my child taking part in all of the activities described in the information relating to the trip. **If not, please provide written details separately.**

I understand that if the party leader considers the behaviour of my child to be unsatisfactory or could in any way jeopardise his /her own safety or that of others, that my child will be excluded from activities or, in the extreme, be asked to return home early at my expense.

I understand that it is vital for all children to obey, without question, the instructions of the Youth Group Leaders.

I understand that while the Youth Group Leaders in charge of the party will take all reasonable care of the children they cannot necessarily be held responsible for any loss, damage or injury suffered by my child which occurs as a result of the trip.

Medical Detail: please note that all of this information is essential.

Contact details for where the legally responsible adult(s) for the child will be contactable during the time of the trip

1st Name..... Telephone.....

(Please print name)**Mobile.....**

Relationship to child.....

2nd Name..... Telephone.....

(Please print name)**Mobile.....**

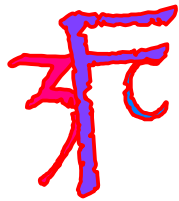
Relationship to child.....

Doctor's Name & Address:.....

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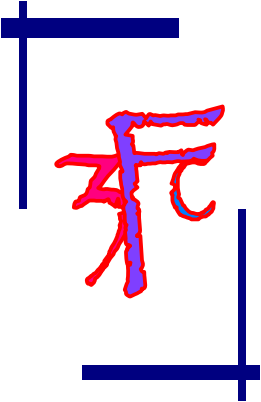
Doctor's Telephone Number:

Please Turn Over to complete form



St Michael's Youth Group
Faith Fun & Friendship

St Michael's
Roman Catholic Church
19 Hayling Rise
Worthing
West Sussex
BN13 3AL
Tel: 01903 264770
www.3fc.org.uk



Has your child ever had the following:-

Asthma or Bronchitis	Yes	No
Heart Condition	Yes	No
Fits, fainting or blackouts	Yes	No
Severe Headaches	Yes	No
Diabetes	Yes	No
Allergies to any known drugs or medication	Yes	No
Other allergies e.g. food, material, insect bites etc	Yes	No
Other illness or disability	Yes	No
Any recent contact with contagious diseases and infections	Yes	No
Immunisation Status – has your child received vaccinations against tetanus in the last ten years	Yes	No
Is your child receiving medical treatment of any kind from your doctor or hospital (if yes give details below)	Yes	No
Has your child been given specific medical advice to follow in emergencies (if yes give details below)	Yes	No

Date of last tetanus injection:

Any known allergies or dietary requirements:

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Details of prescribed medication to be taken: *(all medicine to be labelled with child's name and instructions and handed to Group Leader before departure)*

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Please indicate any medical conditions including all relevant information

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Signed: **Date:**

Please Print Name:

Relationship to child:.....