

# Carrick Canoe Club

## Junior member consent form

Name of Young Person:	Date of Birth:
Home Address:	Postcode:
Home Telephone Number:	
Parent/Guardian Contact Number – Day:	Night:

### ADDITIONAL CONTACT

Please give details of additional contact in case of an emergency.  
(Please state relationship e.g. aunt, grandparent, friend, etc)

Name:	Relationship:
Address:	Postcode:
Contact Number - Day:	Night:

In an emergency and/or if I am not contactable, I am willing for my child to receive necessary hospital or dental treatment including an anaesthetic.

YES  NO  (Please tick)

### MEDICAL INFORMATION

NAME OF DOCTOR:.....

DOCTORS ADDRESS:.....

DOCTORS TELEPHONE NUMBER:.....

### OTHER INFORMATION

Can your son/daughter swim 25 metres? (Please circle)	Yes	No
Can your son/daughter swim 50 metres?(Please circle)	Yes	No
Can your son/daughter swim confidently in cold water? (Please circle)	Yes	No

To help us assess appropriate waterproofs please tell us your son/daughters approx. -

Height -

Weight -

Boot size -

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

Have you ever had:	Yes/No	If you answer yes please give details, including dates
1. Heart trouble, angina, raised blood pressure?	Y/N	
2. Asthma, bronchitis, tuberculosis or other lung condition?	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. hayfever, reaction to medicine or insect bites)?	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 date of 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 within 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 that 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 PLEASE INFORM US IMMEDIATELY

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

I give permission for ..... to take part in the mentioned activities arranged by the Carrick Canoe Club and agree to his/her participation in any or all of the activities described. I acknowledge the need for obedience and responsible behaviour on his/her part.

I confirm that I have no objection to the information given on this form being held on computer.

Do you have any objection to photographs of your son/daughter/ward being used for publicity purposes?

Yes  No

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_