2024 Adult Consent / Medical Form

Complete in BLOCK CAPITALS

Before returning this form please answer and complete all questions in full

Name of course or activity: _____Paid yearly membership date:___/___/_____

Full name: _____Date of birth & age:____/____/_____(____)

Gender identity: _____Ethnicity:_____ Employment status:_____

Home address:_____ Postcode:_____

Email address:_____(tick box to be added to adult mailing list) ☐

Emergency contact details

Contact no.1:**(name)** _____**(relationship to adult)**_____**(phone number)** _____

Contact no.2:**(name)** _____**(relationship to adult)**_____**(phone number)** _____

Photography consent

Please delete as appropriate:

I do / I do not allow images of myself to be used in publications related to the Community Centre.

For example our Social media pages and Website (Ask staff for more information on how images will be used)

SIGNED: _____**PRINT**:_____**DATE**:___/___/_____

Health Form

Please delete as appropriate:

Do you have any additional needs, health issues or disabilities we should be made aware of?

Yes / No If yes give details: _____

Are you receiving any medical treatment at present?

Yes / No If yes give details: _____

Do you have any allergies or dietary requirements that we should be aware of?

Yes / No If yes give details: _____

PERMISSION TO CONSENT TO MEDICAL TREATMENT

In the event of medical attention being required, I authorise the Activity/Project Leader to administer any relevant medical assistance or to call a doctor or ambulance to provide further assistance.

Name of your Doctors:_____Phone number:_____

SIGNED: _____ **DATE**: ___/____/_____

Thank you.

I can confirm that the details on the reverse of this form are up to date and true to the best of my knowledge.

Signature	Print Full Name	Date