



# MEDICAL FORM

**THIS FORM IS DOUBLE SIDED – PLEASE ENSURE YOU TURN OVER**

Name:.....

Date of birth:..... Age:.....

Next of Kin:..... Relationship:.....

Home telephone Number:.....

Work:.....

Mobile:.....

Doctor:..... Tel Number:.....

**It is your responsibility to make known any potential medical conditions that may affect you during the activities associated with the programme you will be taking part in. Please therefore provide as many details as possible. This information will be shared with the coaches at events and training.**

**Have you ever suffered from any of the following conditions:**

- |                                   |     |    |
|-----------------------------------|-----|----|
| • Asthma / bronchitis             | Yes | No |
| • Heart Conditions                | Yes | No |
| • Fits, faints or blackouts       | Yes | No |
| • Severe Headaches                | Yes | No |
| • Diabetes                        | Yes | No |
| • Travel Sickness                 | Yes | No |
| • Allergies to medication         | Yes | No |
| • Any other allergies             | Yes | No |
| • Other illnesses or disabilities | Yes | No |
| •                                 |     |    |

**If you have answered yes to any of the above, please provide details in the box below**

Details:

**When did you last have a tetanus vaccination?      Year:.....**

**Are you currently taking any medication at the moment? If so please specify.**

**Are you suffering / recovering from any injury which may affect your involvement within the programme?**

**Consent:**

**I the parent / guardian of ..... Give permission to T293 appointed coach to administer to the named person, any treatment or medication when or if necessary.**

**Further, if the case arises I authorise the T293 appointed supervisor to take my son / daughter to hospital and give my full permission for any treatment required, to be carried out in accordance with the hospital's diagnosis. I understand I shall be notified, as soon as possible, of the hospital visit and any treatment given by the hospital.**

**Signed: ..... (Parent / guardian)**

**Name:.....**

**Date:.....**

**Name of sailor:.....**