UKWA Class Association
Medical consent and emergency contact form

THIS FORM IS DOUBLE SIDED – Please complete all sections in block capitals

Sailor details:

Sailor name	
Home address	
Date of birth	
Age	
Sail number	
Squad / class	

Emergency contacts

Emergency contact	
Name	
Relationship	
Home number	
Work number	
Mobile number	

Alternative emergency contact	
Name	
Relationship	
Home number	
Work number	
Mobile number	

If different from above

Mother's name		Work number	
Home number		Mobile number	
Father's name		Work number	
Home number		Mobile number	

Doctors details

Doctor's name	
Doctors address	

Work 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 organisers and coaches at events and training.

Have you ever suffered from any of the following conditions:

- Asthma / bronchitis **Yes** **No**
- Heart conditions **Yes** **No**
- Fits, fainting or blackouts **Yes** **No**
- Severe headaches **Yes** **No**
- Travel sickness **Yes** **No**
- Sea 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.

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

Are you currently taking any medication? If so please specify:

Are you suffering / recovering from any injuries which may affect you sailing?

Are you vegetarian? **Yes** **No**

Do you have any food allergies? If so please specify:

Consent

I the parent / guardian of ..... give permission to the organisers of activities during the period of training and events to administer any relevant treatment or medication to the above named participant when or if necessary.

In an emergency situation I authorise the organisers to take my son/daughter to hospital and give my full permission for any treatment required to be carried out in accordance with the hospitals diagnosis. I understand that I shall be notified, as soon as possible, of the hospital treatment given by the hospital.

I will notify the class if there are any changes in my child's circumstances.

Signed: ..... (parent/guardian)

Name: ..... (please print) **Date .....**