

MEDICAL CONSENT FORM

Over 18's

Animate Youth Ministries

Low House, Crab Street, St. Helens WA10 2BE

Reg Charity No. 232709 *Animate is the Youth Service of the Archdiocese of Liverpool*



OVER 18's MEDICAL CONSENT FORM

Please read and fill in this brief form, making sure to sign the declaration of consent.

PERSONAL INFORMATION

Surname: _____ Name: _____

Date of Birth: _____ Age: _____

Address: _____

Telephone Numbers: _____ Home: _____

Work: _____ Mobile: _____

MEDICAL INFORMATION

A. Have you any conditions needing ongoing treatment (including medication)? **YES / NO**

If YES, please give details: _____

B. Have you been treated within the past 2 years for any significant health issue? **YES / NO**

If YES, please give details: _____

C. Please outline any special dietary requirements: _____

D. Are you a vegetarian? **YES / NO**

E. What type of pain/flu medication may you be given if necessary?

F. Do you have a particular disability? **YES / NO**

If YES, please give details: _____

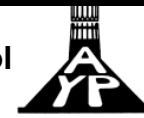
G. Are you allergic to any medication? **YES / NO**

If YES, please give details: _____

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MEDICAL INFORMATION CONTINUED

H. To your best knowledge, have you been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be contagious or infectious? **YES / NO**

If YES, please give details: _____

I. Do you have any psychological problems? **YES / NO**
 (Eating disorders, Schizophrenia, poor mental health or depression)

J. When did you last have a tetanus injection? _____

K. Are there any personal details that the Coach Leader should be aware of? **YES / NO**

If YES, please give details (use a separate sheet if necessary):

DECLARATION

I agree to participate in the activities described. I acknowledge the need to behave responsibly.

I am happy for this information to be shared amongst those who will be responsible for me during my time in Lourdes. I am also happy that if there is a significant past history my form will be passed on to the Medical Team who may need to seek further information from me.

I agree to receive medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present. I understand the extent and limitations of the insurance cover provided.

J'accepte de recevoir tous les médicaments prescrits et tous les traitements dentaires médicaux ou chirurgicaux en cas d'urgence, y compris les anesthésies et les transfusions sanguines considérées nécessaires par les médecins présents.

Signed: _____

Print Name: _____ Date: _____

Alternative Emergency Contact:

Name: _____ Telephone: _____

Mobile: _____

Name of family Doctor: _____ Telephone: _____

Address: _____

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