Archdiocese of Liverpool Lourdes Youth Pilgrimage

EMERGENCY CONTACT DETAILS (cont.)

Second named person:

Name: ______________________________

Relationship to young person: ______________________________

Telephone Numbers Mobile: ______________________________

Work: ______________________________ Home: ______________________________

Name of Family Doctor:______________________________ **Telephone:** ______________________________

Address: ______________________________

CONSENT DECLARATION FOR STAFF MEMBERS

I agree to participate in the activities described and confirm that I am fit to participate.

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: ______________________________

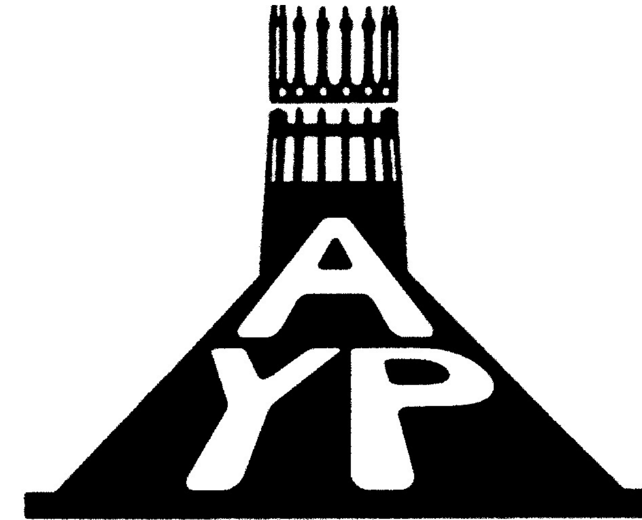
Print Name:______________________________

Date: ______________________________

Animate Youth Ministries
Lowe House, 99 Crab Street, St. Helens WA10 2BE
Reg Charity No. 232709 *Animate is the Youth Service of the Archdiocese of Liverpool*

Archdiocese of Liverpool

Lourdes Youth Pilgrimage



MEDICAL CONSENT FORM

STAFF

Please complete and return the Medical Consent Form to your Coach Leader

Name of Staff Member:______________________________

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MEDICAL CONSENT FORM FOR STAFF MEMBERS

Please read and complete this brief form, making sure you sign the declaration of consent.

PERSONAL INFORMATION

Surname: ____________________ **Forename:** ____________________

Date of Birth: ____________________ **Age:** ____________________

Address: ____

____

Telephone Numbers **Mobile:** ____________________

Work: ____________________ **Home:** ____________________

MEDICAL INFORMATION

A. Do you have any medical conditions which require ongoing treatment (including medication)? **YES / NO**

If YES**, please give relevant details:** ________________________________

____

B. Have you been treated within the past two years for any significant health issue (physical or psychological)? **YES / NO**

If YES**, please give relevant details:** ________________________________

____

Please make sure that you are carrying enough medication for the duration of the visit. For inhaler users, please ensure that there is sufficient supply in the hand luggage and suitcase

C. Do you have any allergies? **YES / NO**
(E.g. Penicillin, Gluten, Dairy, Wheat, Nut, Paracetamol, Aspirin etc)

If YES, please give details:________________________________

____

D. If necessary, what type of pain/flu relief medication would you use?

____

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MEDICAL INFORMATION CONTINUED

E. Do you have a disability that you feel we should be aware of? **YES / NO**

If YES**, please give details:** ________________________________

____

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

If YES**, please give details:** ________________________________

____.

G. When did you last have a tetanus injection? ____________________

H. Are there any other details that you feel the leader should be aware of? **YES / NO**

If YES**, please give details:** ________________________________

DIETARY REQUIREMENTS

Does this person have any special dietary requirements? **YES / NO**

If YES**, please give details:** ________________________________

EMERGENCY CONTACT DETAILS

Please provide contact details of those people we would need to contact in the event of an emergency.

First named person:

Name: ________________________________

Relationship to young person: ________________________________

Telephone Numbers Mobile: ____________________

Work: ____________________ Home: ____________________