

Port Dinorwic Sailing Club



Beginner Youth Training 2010

MEDICAL FORM (2 Pages)

Name:

Date of birth: **Age:**

Next of kin: **Relationship:**

Home:

Work:

Mobile:

Doctor: **Tel:**

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, fainting 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.

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

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

Are you vegetarian? Do you have any food allergies?

Consent

I the parent/guardian of give permission to the PDSC appointed supervisor to administer to the named person, any treatment or medication when or if necessary.

Further, if the case arises I authorise the PDSC 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 that I shall be notified, as soon as possible, of the hospital visit and any treatment given by the hospital.

Signed: (parent/guardian)

Name:

Date: