**Permission Slip - Club Event**

I give consent for my child (name)……………………………………………………………………..to take part

in (event)………………………………………………………………………………………………………….. taking place

at (venue)…………………………..………………………………………………………………………………………

I understand the event will start at………………………………. and finish at………........................ and that I will make suitable arrangements for the transportation of my child to and from the event.

\*I can confirm that the medical details related to the named child, and provided on the Parental Consent Form completed at the start of this Membership Year are up to date and valid. **YES/NO** (If NO please update in the medical section on the reverse side of this form.)

\*I can confirm that the two emergency contacts related to the named child, and provided on the Parental Consent Form completed at the start of this Membership Year are up to date and valid. **YES/NO** (If NO please update in the emergency contact section on the reverse side of this form.)

\*I can confirm that I provide consent for the named child to be photographed and/ or videoed during this activity and the pictures may be used within displays, the website, or for marketing and advertising purposes and the local press may also photograph. Photographs may be used in publicity and marketing for NFYFC also. **YES/NO**

\*I understand that the insurance policy is made available to me via the County Office or NFYFC website and understand the extent and limitations of the insurance cover provided. **YES/NO**

**Childs Name: ……………………………………………………………………**

**Parent/ Guardian Printed Name:……………………………………………..**

**Parent Signature: ………………………………………………………………...**

**Date: ……………………………………………………………………………….**

**MEDICAL DETAILS**

**(only complete if amendments to the original County Event parental consent form are required)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Doctors Name: |  |  | Doctors Telephone: |  |

|  |  |
| --- | --- |
| Doctors Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Has this member ever suffered from any of the following conditions: Diabetes, Asthma, Bad period pains, Migraine, Epilepsy, or any other illness? | Yes |  | No |  | *If yes, please give details...* |
|  |
| Is this member allergic to anything (e.g. antibiotics, penicillin, elastoplast, aspirin or any such medicines, any particular food etc.)? | Yes |  | No |  | *If yes, please give details...* |
|  |
| Is this member receiving any medical treatment or on any prescribed medication? | Yes |  | No |  | *If yes, please give details...* |
|  |
| Does this member have any disabilities, additional needs and/or behavioural difficulties? | Yes |  | No |  | *If yes, please give details...* |
|  |
| Details of any medication to be taken, include frequency and any relevant side effects? | Yes |  | No |  | *If yes, please give details...* |
|  |
| Does this member have any other additional needs? (Dietary, wheel chair access, etc). | Yes |  | No |  | *If yes, please give details...* |
|  |
| Any other relevant information | Yes |  | No |  | *If yes, please give details...* |
|  |

**Please delete as appropriate**

\* The medical information provided above is correct to the best of my knowledge **Yes/No**

\* In the event of illness or accident requiring hospital treatment I understand that the responsible person at the

 club/county will make every effort to contact me **Yes/No**

\* In an emergency doctors/surgeons will make the decision regarding the necessary treatment without my consent **Yes/No**

**EMERGENCY CONTACT DETAILS (must be parent/guardian)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Contact 1** |  | Name: |  |  | Mobile Tel: |  |
|  |  |  |  |  |
| Tel Number: |  |  | Alternative Tel Number: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Contact 2** |  | Name: |  |  | Mobile Tel: |  |
|  |  |  |  |  |
| Tel Number: |  |  | Alternative Tel Number: |  |