



## MEDICAL CONSENT FORM

Anything written on this form will be held in confidence. Our coaches need to know these details in order to meet the specific needs of every player.

**FULL NAME:**

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**ADDRESS:**

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**HOME TEL:** ..... **AGE:** .....

**DATE OF BIRTH:** ..... **MALE/FEMALE (Please circle)**

**EMERGENCY TEL (1):**..... **(2):** .....

**NAME AND TEL OF G.P.:** .....

**DETAILS OF ANY KNOWN ALLERGIES, CONDITIONS, MEDICATION BEING TAKEN:**

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**ANY OTHER SPECIAL NEEDS, REQUIREMENTS OR DIRECTIONS THAT WOULD BE HELPFUL FOR THE COACHES TO KNOW ABOUT:**

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I will inform the coaches of any important changes to my health, medication or needs and also of any changes to our address or phone numbers given.

In the event of illness, I give permission for medical treatment to be administered where considered necessary by a nominated first aider, or by suitably qualified medical practitioners. I authorise a qualified medical practitioner to provide emergency treatment or medication.