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| hccb&w |  | **FORM OV 7B (CSF4259)**  **SELF-CONSENT FORM FOR ADULTS**  **(or young people living independently)** |
|  |  | **Establishment:**  Edwinstree Middle School |

**To be completed by visit leader/organiser**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Visit: |  | | | | |
| Visit Leader: |  | | | | |
| Date of Visit: | From: | | To: | | |
| Is a photograph of participant required: | | | ~~Yes~~  / No | | |
|  | |  | | | |
| **To be completed by participant.** | | | | | |
| Full name: Date of Birth:  Passport Number (where required) | | | | | | |
| Do you: | | | | | | |
| * Have a medical condition requiring medical treatment or medication? | | | | Y/N | | |
| * Have an allergy to certain medications? | | | | Y/N | | |
| Please give details of medical condition/treatments or allergies to medications below: | | | | | | |
| Have you been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may become contagious or infectious? | | | | Y/N | | |
| If yes, give details: | | | | | | |
| Have you supplied details of your Inoculations record with this form? | | | | | Y/N | |
| Do you have any special dietary requirements?  If yes, give details: | | | | Y/N | | |
| I wish to draw the following to the group leaders attention (e.g. allergies, phobias, recent operations and treatments, conditions which may affect fitness to participate in certain activities): | | | | | | |
| **SWIMMING ABILITY:** (only applicable if water-based activities are planned. Are you water-confident / competent?) | | | | | | |

|  |  |  |  |
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| **EMERGENCY CONTACT INFORMATION** | | | |
|  | | MAIN | ALTERNATIVE |
| Name: | |  |  |
| Relationship: | |  |  |
|  | |  |  |
| Address: | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
| Telephone Numbers: | Day: |  |  |
|  | Evening: |  |  |
|  | Other: |  |  |
| **FAMILY DOCTOR DETAILS** | | | |
| Name: | | | |
| Address: | | | |
|  | | | |
|  | | | |
| Telephone Numbers: |  | | |
| NHS Number (if known) | | | |

|  |  |
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| **DECLARATION**  I have received and understood the details of the visit.  I confirm that I am in good health and fit to participate in the activities described.  I agree to receive medical treatment as considered necessary by the medical authorities present.  I undertake to inform the visit organiser as soon as possible of any change in medical circumstances between the date signed and the commencement of the event. | |
| Signed: | Date: |
| Name in Capitals: | |
| Address:  Postcode: | |
| Telephone No: | |

The information on this form should be retained by the establishment’s emergency contact.

This form or a copy may be taken by the visit leader on visits outside the UK.