

Medical Consent Form



This form is to be completed by the person with parental responsibility for each Pony Club Member.

Date of Camp / Course / Visit From _____ To _____

BRANCH / LINKED CENTRE _____

Name of Member _____ Date of Birth ____ / ____ / ____

Name(s) of Parent / Guardian _____

Authorised contact if parent unattainable _____ Tel. No. _____

Address of Parent / Guardian _____

Tel. Number (Day) _____ (Night) _____

Fax Number _____ Email _____

Member's General Practitioner NAME _____

NAME & ADDRESS OF PRACTICE _____

Does he / she suffer from:

- | | | | |
|-------------------------------|----------|--------------------------------|----------|
| * Asthma | YES / NO | * Epilepsy | YES / NO |
| * Migraine | YES / NO | * Diabetes | YES / NO |
| * Dyslexia | YES / NO | * Hay Fever | YES / NO |
| * Heart / Lung Disorder | YES / NO | * Bone / Joint Impairment | YES / NO |
| * Vision / Hearing Defects | YES / NO | * Allergy to Drugs / Food | YES / NO |
| * Gynaecological Disorders | YES / NO | * Ear, Nose & Throat | YES / NO |
| * Gastro-intestinal Disorders | YES / NO | * Any skin complaint | YES / NO |
| * Any other medical Disorder | YES / NO | * Special dietary requirements | YES / NO |

Please state insulin medication and detail emergency procedures for hypos on the next page

If yes to any of the above, please specify the nature of the problem

Are contact lens worn? YES / NO

Religion, if applicable to Medical Treatment _____

Are there any other problem of which the Safeguarding Officer should be made aware? YES / NO

Does he / she regularly take any form of medication? YES / NO (If so, please detail on next page)

Does he/ she need to carry an adrenaline auto-injector? YES/NO Reason: _____

What type and dose is the adrenaline auto-injector? _____

Are there any current injuries / operations / medical treatments? YES / NO If so, please explain.

Any previous operations, e.g. appendix? YES / NO If so, please explain

Has your child received all expected immunisations including tetanus? YES / NO

If no, please detail what was missed _____

Medical Consent Form



Medicines Administration by Member Of Staff Or Member

Whilst my child is away, I authorise you to give the following medicines to my child (please delete the paracetamol line if you do not wish for your child to be give paracetamol under any circumstances). Please state if your child carries and takes their own supply of medication e.g. asthma inhalers, contraceptive pills / implants.

All the medicines specified below have been prescribed by a registered and licensed medical practitioner and will be provided in the original packet / box / bottle with the child's name and date of birth clearly marked. I agree that the medicines are necessary for my child, that they will be given without intending harm to the child and I indemnify The Pony Club or its Branches / Linked Centres against any loss or claim associated whatsoever with the administration of the medicines specified below.

Name of medicine	Strength of medicine	How much to give each time	Type (tablet / liquid / inhaler)	When to be given (time of day)	Any other information about this medicine
MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICINES (please note if this box is not completed no medicines will be given. Please state if no known allergies.)					
Paracetamol	I authorise the person in charge or their designated deputy to give up to 2 doses of paracetamol of a dosage suitable for the age and weight of my child in a form suitable for my child. I understand that on the administration of the second dose I will be contacted regardless of the time of day or night.				

In the event of my daughter / son requiring emergency medical or dental treatment whilst taking part in the Pony Club activity as described above, and an Officer or other responsible adult being unable to contact either myself or other person with a parental responsibility for my daughter / son, I hereby authorise the District Commissioner / Centre Proprietor or other Official of the Pony Club to obtain such medical or dental treatment for my child as they, in their absolute discretion, think necessary after consultation with a medical or dental practitioner. This authority extends to all medical and dental treatment including the giving of an anaesthetic where necessary.

Data provided will be stored and used in line with current data protection regulations.

Signature:			
Print Name:		Date:	
Role / Relationship:			