**WEST HANTS PONY CLUB**

SENIOR CAMP 2026

Sunday 2nd to Thursday 7th August 2026

Tenantry Far, Rockbourne, Fordingbridge. SP6 3PB

**MEDICAL FORM**

Please complete and email to wh.ponyclub@gmail.com

MEMBER’S NAME INC. SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILE PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALTERNATIVE PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORISED CONTACT IF PARENT/
GUARDIAN NOT AVAILABLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORISED CONTACT PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give consent for my child to be examined by the appointed doctor and treated if the need arises. I give consent for my child’s horse/pony to be examined by the appointed camp vet or farrier and treated if the need arises and I accept responsibility for any costs incurred. I agree not to visit camp unless by prior appointment with organiser or camp mum.

SIGN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RIDER’S DOCTOR (phone provide name & phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOES HE/SHE REGULARLY TAKE ANY FORM

OF MEDICATION? YES/NO

IF YES PLEASE GIVE DETAILS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All medication should be given to the camp nanny on arrival

DOES HE/SHE HAVE ANY VISUAL HEARING PROBLEMS? YES/NO

IF YES PLEASE GIVE DETAILS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF LAST TETANUS INJECTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE ADVISE OF ANY ADVERSE REACTIONS

TO THE ABOVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOES HE/SHE SUFFER FROM ANY OF THE FOLLOWING
(please stick all that apply):

* Asthma
* Epilepsy
* Migraine
* Diabetes
* Dyslexia
* Hay Fever
* Skin Complaint. Please detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOES HE/SHE SUFFER FROM ANY ALLERGIES? YES/NO

IF YES PLEASE PROVIDE DETAILS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other problems relating to your son or daughter’s medical history that our welfare officer should be aware of?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign to give permission by Parent/Guardian for Camp mum to administer paracetemol/calpol

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event of my son/daughter requiring emergency medical or dental treatment whilst taking part in the Wet Hants activities 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 son/daughter, I hereby authorise the DC or any West Hants official 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.  Also to go off camp site to swimming and venues of interest accompanied by Camp Officials. By ticking yes you are giving consent to the above.

* YES

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN