COBNOR POINT, CHIDHAM, CHICHESTER, WEST SUSSEX, PO18 8TE.
Tel: 01243 572791 Email: sail@cobnor.com
www.cobnor.com
Centre Manager: Mark Murray-Brown BA Ed Hons.

PARENTS CONSENT FORM

I wish my son/daughter .....

Date of Birth ...../...../.....AGE at start of course.....Ethnicity.....
To be allowed to take part in adventurous outdoor activities at, and away from the centre

From (Date/Time).....To (Date/Time) .....

Course Code.....Course Title.....

And, having read the Booking Terms & Conditions and Course Programme (If applicable), agree to his /her taking part in any or all of the activities.

I have ensured that my child understands that it is important for his/her safety and for the group that any rules and any instructions given by the staff in charge are obeyed.

I understand that:
a) My son/daughter should be water confident to partake in water based activities.
b) While the Centre staff and helpers in charge of the party will take all reasonable care of the young people, unless they are negligent they cannot be held responsible for any loss, damage or injury suffered to my son/daughter arising during or out of the activity.

Please delete and complete the following as is appropriate.

My child has: **No illness, allergy, physical or mental impairment disability.**

The following illness, physical or mental impairment disability (please detail below)

.....

Which necessitates the following medical treatment .....

.....

I consent to any emergency medical treatment necessary during the course of the visit.

Signed..... **(Parent/Guardian). Date...../...../.....**

	Home Details	Mums Work	Dads Work	Emergency Contact
Flat/House No				
Street				
Town/City				
Post Code				
Telephone No				
Mobile No				
Email Address				
Relationship	→→→→→→→→→→→→→→→→→→→→			

PLEASE COMPLETE THE OTHER SIDE

MEDICAL QUESTIONNAIRE

Name and Address of Family Doctor.....
.....
Telephone number.....

Has your child had any of the following?

Asthma or bronchitis	YES	NO
Heart Condition	YES	NO
Fit, Fainting or Blackouts	YES	NO
Severe Headaches	YES	NO
Diabetes	YES	NO
Allergies to any known drugs	YES	NO
Any other allergies i.e. insect bites etc	YES	NO
Other illness or disabilities	YES	NO
Any recent contact with contagious diseases and infections	YES	NO

If the answer to any of these questions is **YES** please give details on a separate sheet of paper, which should be firmly attached to this form.

Is your child receiving medical treatment of any kind from either your Family Doctor or Hospital? **YES** **NO**

Has your child been given specific medical advice to follow in Emergencies? **YES** **NO**

If the answer is **YES** to either of these questions please give details below (Including dosage of medication) .
.....
.....
.....

IMMUNISATION STATUS

Has your child received vaccination against Tetanus in the last 10 years? **YES** **NO**

For residential trips, please state any special dietary requirements.
.....
PRINTED NAME: .....
SIGNED (Parent / Guardian) .....**DATE**...../...../.....

Please note photographs may be taken during these sessions and used for publicity. If you have any objections please inform the Centre Manager in writing.

Updated January 2010

PLEASE COMPLETE THE OTHER SIDE