**Consent Form**

Name of group: Gold cycling

Event: Defensive cycling and navigation day, 16th February 2024

Venue: Queens Road to Stratford and back.

This form must be completed by a parent/guardian/next of kin in order for the participant to take part in the activity. It should be signed and returned to: Dave Leach.

NB: **IF THIS FORM IS NOT COMPLETED IN FULL AND RETURNED TO THE PERSON NAMED ABOVE THE PARTICIPANT WILL NOT BE ABLE TO TAKE PART IN THE EVENT.** This is because the insurance forms and details have to be completed and sent through to the council.

Full name of participant ..................................................................................

Date of birth ....../....../......

Address .............................................................................................................................

...................................................................................... Postcode ...................................

Telephone number(s) ........................................................................................................

The person to contact in case of emergency during this event is:

Name ........................................................................................................................

Relationship to participant....................................................................................

Address ........................................................................................................................

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Telephone number(s) ........................................................................................................

Should the above not be available, please contact:

Name ........................................................................................................................

Relationship to participant ....................................................................................

Address ........................................................................................................................

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Telephone number(s) ........................................................................................................

Participant’s registered GP:

Name ........................................................................................................................

Address ........................................................................................................................

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Telephone number(s) ........................................................................................................

National Health Number ....................................................................................................

Date of last anti-tetanus injection (if known) ...../...../.....

Does the participant suffer from any allergies? Yes No (Please circle)

eg: medicine, food, insects . . .*(If yes please give details overleaf if necessary)*

Does the participant have any medical Yes No (Please circle)

conditions of which we should be aware? eg: asthma, fits, migraine, epilepsy.

*(If yes please give details overleaf if necessary)*

Does the participant have any disability/ Yes No (Please circle)

special needs of which we should be aware?

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Is the participant taking any medication? Yes No (Please circle)

*(If yes please give details)*

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Has the participant been in contact with Yes No (Please circle)

or suffered from any disease which is or may be

contagious or infectious, in the **last 4 weeks**?

*(If yes please give details)*

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**Over the Counter Medicine Disclaimer**

After evaluating previous expeditions and explorations, it has been noted that on occasions, it has been necessary to treat individuals with simple painkillers and anti-allergy medicines to aid in recovery and the continued participation within the event.

To make sure we continue to provide the highest possible care and welfare, we are now asking for separate consent from parents/ legal guardians to allow adult leaders (aged 18 +) to, on request, issue the following, ‘Over the Counter’ non prescriptive drugs.

**Paracetamol / Ibuprofen / Anti-Histamines.**

Any medicine that is administered will be documented and the parent/legal guardian informed on return from the event.

**Declaration**

Please note that this declaration can only be signed by those with parental responsibility/ next of kin (NB: this does not include a foster carer).

I give permission for/ acknowledge .............................………………………………..…. to take part in / is taking part in the event named above.

I consider he/she to be medically fit to participate in the activities outlined.

I give permission for: (Please circle box and **individually initial**)

Paracetamol, □ ………………..

Anti histamines □ …………….….

Ibuprofen □ ………………..

to be given by leaders ( aged over 18) if requested by the above named.

**I undertake to inform the leader should any of the above information change by the date of the event.**

In an emergency and/or I cannot be contacted, I am willing for this participant to receive necessary hospital or dental treatment including an anaesthetic:

Yes No (*Please circle*)

Signed (parent/guardian/next of kin) .............................................................................

Date ...../...../.....