

MEDICAL FORM/



PERMISSION TO CAMP

Please complete this form and pass back to Team X-Treme. We will hold them all in a central location over the weekend. All information contained within will be treated as strictly confidential.

EVENT X-Treme		DATE 27 th – 30 th August 2010		ORGANISERS Team X-Treme	
Attendee Name:					
E-mail Address:		Date of Birth:			
		Contact No:			
Home Address:					
Postcode:					
Emergency Contact Name:		Emergency Contact No:			
Emergency Address: (If different to above)		Relationship:			
Doctors Name:		Surgery Phone No:			
Surgery Address:		NHS Number:			
Do you suffer from any allergies or disabilities?	YES	NO	If YES please give details:		
Do you take any medicines or pills?	YES	NO	If YES please give details:		
Have you been given an anti-tetanus vaccination during the last 10 years?				YES	NO
Do you object to being given the following?					
An Anaesthetic	YES	NO	Blood Transfusion	YES	NO
Paracetamol	YES	NO			
State any other details or instructions that the organisers should be aware of:					
By signing this form, I agree that the information provided above is correct and have permission to attend the event and participate in all activities.					
Name:		Signature:			
Date:					