



FORM OSA2 (2013) (Young Person)
Consent to Activity, Medical Details and Treatment Form

Name of young Person

Date of birth Male Female

Home address
Tel no.

Name of education establishment

Visit to

From (date) To (date)

Emergency contact telephone numbers (home/mobile/work)

1

2

3

Name, address and telephone number of own doctor

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Does he/she suffer from: asthma, chest complaints, hay fever, migraine, fits or faints, bad period pains, travel sickness, diabetes, attention deficiency, hyper-activity or any other condition, illness or disability? If so, give details:

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Is he/she allergic to anything (e.g. Aspirin, antibiotics, any particular food or drug)?
 If so, give details

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Is he/she having any medical treatment at present? If so, please give written details of treatment and medicines etc (these **must** be handed to the Party Leader)

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Are there any reasons that you know of that stop them from participating fully in the planned activities?

Are there any activities in which they should not participate?

Date of anti-tetanus injection (if known)

Is there any other relevant information which the Party Leader should be aware of?

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Please indicate any special food dietary/requirements where applicable

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I wish my child to take part in the journey/activities and having read the information provided, agree to him/her taking part in any or all of the activities described.
I understand that, while staff in charge of the party will take all reasonable care of the young people, they cannot necessarily be held responsible for any loss, damage or injury suffered by my son/daughter arising through the visit.

Name (please print)

SignatureDate

**All journeys and activities carry some amount of risk*

CONSENT TO MEDICAL TREATMENT

I,(your name in block capitals please) agree to my son/daughter receiving any emergency or other medical treatment as deemed urgent, necessary and/or in the best interest of my son/daughter by the medical authorities present. This includes dental, medical or surgical treatment, the use of anaesthetic's or blood transfusion. I also agree to the release of relevant and necessary medical information to educational establishment staff by the GP if circumstances are deemed necessary and appropriate.

Signed Date
 (Parent/Guardian)