



FORM OV 7B (CSF4259)
SELF CONSENT FORM FOR ADULTS

Establishment:

To be completed by group leader/organiser

Visit:			
Group Leader:			
Date of Visit:	From:	To:	
Is a photograph of participant required:		YES / NO	

To be completed by participant.

Full name:	
Do you:	
<ul style="list-style-type: none"> Have a medical condition requiring medical treatment or medication? Have an allergy to certain medications? 	Y/N Y/N
Please give details of medical condition/treatments or allergies to medications below:	
Have you been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may become contagious or infectious? If yes, give details:	
Y/N	
Do you have any special dietary requirements? If yes, give details:	
Y/N	
I wish to draw the following to the group leaders attention (e.g. allergies, phobias, recent operations and treatments, conditions which may affect fitness to participate in certain activities):	
SWIMMING ABILITY If water based activities are planned, please detail your swimming ability below:	

EMERGENCY CONTACT INFORMATION		
	MAIN	ALTERNATIVE
Name:		
Relationship:		
Address:		
Telephone Numbers:	Day:	
	Evening:	
	Other:	
FAMILY DOCTOR DETAILS		
Name:		
Address:		
Telephone Numbers:		

<p>DECLARATION I have received and understood the details of the visit.</p> <p>I confirm that I am in good health and fit to participate in the activities described. I agree to receive medical treatment as considered necessary by the medical authorities present.</p> <p>I undertake to inform the group leader as soon as possible of any change in medical circumstances between the date signed and the commencement of the event.</p>	
Signed:	Date:
Name in Capitals:	
Address:	
Postcode:	
Telephone No:	

THIS FORM OR A COPY MUST BE TAKEN BY THE GROUP LEADER ON THE VISIT. A COPY SHOULD BE RETAINED BY THE EMERGENCY CONTACT.