

MIKE HARRIS SCHOOL OF SQUASH

Medical, Dietary and Photographic Consent Form

1. Details of Squash Activity:

I (player's name) _____

Is taking part in the Mike Harris School of Squash Camp - Date: _____

2. Medical Information:

a. Are there any conditions that require medication during the MHSS Camp? YES/NO
If YES, please give brief details:

b. Are you allergic to any medication? YES/NO. If YES, please specify:

c. To the best of your knowledge, have you been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be contagious or infectious?

YES/NO

If YES, please give brief details:

d. When was last tetanus injection? _____

I will inform the person in charge as soon as possible of any changes in the medical or other circumstances between now and the specified end of the activity.

3. Any Dietary Requirements

Please outline any special dietary requirements, if necessary.

4. Photography and Recorded Images

Mike Harris School of Squash recognises the need to ensure the welfare and safety of all young people in sport. We will not permit photographs, video or other images of children/young people or adult to be taken without the consent of the parents/carers and adult applicants.

Mike Harris School of Squash will take all possible steps to ensure these images are used solely for the purposes they are intended. If you become aware that these images are being used inappropriately you should inform Mike Harris School of Squash immediately.

I (applicant or *parent/carer*) consent / do not consent to Mike Harris School of Squash photographing or videoing my involvement / child's involvement in squash for the period of time shown on this form for the purposes of publicising and promoting the sport, or as a coaching aid.

Signed: _____ Date: _____

5. Declaration

I agree / do not agree to myself / my child receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

Emergency contact: (Name) _____

Contact telephone numbers (incl. national code):

Work: _____ Home: _____

Mobile: _____ E-Mail: _____

Alternative Emergency contact: (Name) _____

Contact telephone numbers (incl. national code):

Work: _____ Home: _____

Mobile: _____ E-Mail: _____

Name of your family doctor: _____

Tel: No. _____

Address:

Signed: _____ Date: _____

Full Name (Capitals): _____

