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| BAF pill logo final.jpg | **SPECIFIC CONSENT FORM** **2014****For use by those over the age of 18 and for the parents / guardians of those who are under the age of 18.** |

**Data** **Protection** **Act, 1998**

The information that you supply on this form will be used by the British American Football Association for the purpose of maintaining and improving the level of service given for young people within the sport. All information is regarded as confidential and any data collected via this form will be processed or disclosed only within the limits of the data protection notification.

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| Team: |  |
| Visit to: |  |
| Date and times: |  |
| I consent to: |  | (full name) |

taking part in this visit and have read the **accompanying information**. I agree to him/her/me participating in the activities described. I acknowledge the need for him/her to behave responsibly throughout the visit and to follow any rules and instructions given.

Consent is also given for the named individual to be under the care of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of club coach or responsible adult) for the travel to and from the event.

Medical information about your son/daughter/you:

|  |  |  |
| --- | --- | --- |
| Date of birth: |  | (dd/mm/yy) |
| Does your child / you suffer from any condition requiring regular treatment? | Yes [ ]  | No [ ]  |
| If yes please give details: |
|  |
| If you have answered yes do you give your permission for the staff to administer the medication should this be necessary? | Yes [ ]  | No [ ]  |
| Have you or your child to the best of your knowledge been in contact with any infectious or contagious diseases or suffered from anything that may become infectious or contagious in the last three weeks? | Yes [ ]  | No [ ]  |
| If yes please give details: |
|  |
| Are you, your son/daughter allergic or sensitive to any medication? eg penicillin | Yes [ ]  | No [ ]  |
| If yes please give details: |
|  |
| Have you / your son/daughter had any serious medical condition in the last few years that we should know about? | Yes [ ]  | No [ ]  |

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| If yes please give details: |
|  |
| Have you / your son/daughter been immunised against tetanus? | Yes [ ]  | No [ ]  | Date of last injection: |  |
| Please outline any dietary needs or food allergies: |
|  |
| Name of your / child’s doctor: |  |
| Address: |
|  |
| Post code: |  | Tel no: |  |

**I will inform Andy Fuller (****andy.fuller@britishamericanfootball.org** **or 07971 497792) as soon as possible of any changes in the medical or other circumstances between now and the commencement of the visit.**

|  |
| --- |
| Emergency Contact Details |
| I may be contacted by telephoning one of the following numbers: |
| Day: |  | Ev: |  | Mob: |  |
| Home Address: |  |
|  |
| Alternative Emergency Contact |
| Name  |  |
| Relationship: |  |
| Tel: Day |  | Ev: |  | Mob: |  |
| Address: |  |

**Declaration**

I **agree** to me / my son/daughter receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic, as considered necessary by the medical authorities present.

I **agree** to me / my son/daughter receiving a blood transfusion if considered necessary by the medical authorities present.

I understand that I may ask to see a copy of the insurance cover provided in order that I might appreciate the extent and limitations of the policy.

|  |  |  |
| --- | --- | --- |
| Signed: |  | (Parent/Guardian) |
| Print Name: |  | Date: |  |

NB: This form should only be signed by a parent or an individual who holds legal responsibility for the child concerned. If you are 18 years of age then please use the same form to declare medical conditions and provide us with your signature.

This form should be returned to andy.fuller@britishamericanfootball.org or a signed copy should be provided to an identified member of staff on the day.