



ENTRUST OUTDOORS MEDICAL INFORMATION & CONSENT FORM

All participants must complete this form to be accepted onto any Entrust Outdoors course. For all participants under 18, this form should be completed by a parent, guardian, or those with parental responsibility. It should not be completed more than 14 days prior to the visit.

| | | |
|---------------------------------|-----------------------------|---|
| Name Of Participant | Date Of Birth | School/Establishment |
| | | |
| Participant's Address: | | Home telephone Number |
| | | |
| Parent/Guardian/Contact Name(s) | Relationship to participant | Contact numbers: Home: Work: Mobile Best 24 hour contact number |
| Participant's Doctors Name | Address | Telephone |
| | | |

Medical Information:

| Does the participant suffer from any of the conditions below (Please tick YES or NO) | | | |
|--|-----|----|--|
| | Yes | No | If Yes is ticked, please give details including medication taken |
| Asthma | | | |
| Epilepsy | | | |
| Diabetes | | | |
| Bedwetting | | | |
| Food Allergies | | | |
| Medication Allergies | | | |
| Other Allergies | | | |
| Any condition which may be aggravated by physical activities | | | |
| Has the participant suffered from, or been in contact with, any infectious or contagious conditions in the last 4 weeks? | | | |

Please give the approximate date of the participants' last tetanus _____

Further medication information: Please detail any additional information.

Please ensure all medication that the participant may require during the visit is clearly labelled with the participants name and dosage required and given to the school or establishment staff in charge of the participant throughout the visit. If inhalers are required please check they are full and provide a spare. If Epipens or similar are required please ensure 2 are supplied. If the participant is not confident to take the medication please let school/establishment staff know.

By signing below I consent for the participant to receive, if necessary, the proprietary medicines listed below at the dosage appropriate for their age:

| Ailment | Treatment |
|-----------------------------------|---|
| Nasal Congestion and Sore throats | Decongestant Lozenge (e.g. Tunes) |
| Headache | Paracetamol, Calpol (or equivalent) |
| Insect or plant bites or stings | Proprietary cream or spray |
| Sore Lips | Lip Salve or Vaseline |
| Sun Protection | Sun Screen/cream |
| Asthma | Ventolin Inhaler if participants own has run out. This will only be given if YES for Asthma is ticked |

Some visits may have water activities in them. Please tick the box which best indicates the participants swimming ability. **Specialist canoeing and sailing courses will require the participants to be able to swim at least 50m**

| Non-Swimmer | Swim less than 50m | Swim more than 50m |
|--|--|---|
| Special craft only with close supervision or swimming pool | All elementary water activities in sheltered water | Specialist sailing or canoeing activities |
| | | |

Occasionally, photographs and videos are taken of participants undertaking activities for use on our publicity material, Entrust website or on our social media sites. Please tick the box to confirm that photographs of the participant named on this form may be used for these purposes.

By signing below I agree to the participant receiving medication as instructed and any medical, dental or surgical treatment including blood transfusion and anaesthetic as considered necessary by the medical authorities.

I accept that if the participant named on this form does not behave responsibly within the guidance given by the Entrust centre staff, they may be asked to leave the centre. It is my responsibility to make immediate arrangements for them to return home and pay any costs incurred.

I understand the nature of the activities the participant will be undertaking and I consent to the participant named taking part in activities provided by Entrust Outdoors. I declare I have answered all the questions to the best of my ability and have not knowingly withheld any information regarding the physical fitness of the participant.

| Signature (Person with parental responsibility if participant under 18) | Print Name | Date |
|--|------------|------|
| | | |

The data provided will be used to ensure the appropriate care and treatment of participants. It will be shared with health professionals as required.