Wheelton & District Branch of The Pony Club
Medical Consent Form

CONFIDENTIAL

This form is be completed by the person with parental responsibility for each Pony Club Member

Date of Camp/Course/Visit From: ..... To: .....

Name of Member: ..... Date of Birth: .....

Name(s) of Parents/Guardian: .....

Authorised contact if parent unattainable: ..... Relation to Member: .....

Authorised contact telephone number Home: ..... Mobile: .....

Address of Parents/Guardian: .....

.....

Tel. Number (Day): ..... (Night): ..... Email: .....

Member's General Practitioner Name: ..... Telephone Number: .....

Name & Address of Practice: .....

.....

Does She / He suffer from:

Asthma	YES/NO	Epilepsy/Fainting	YES/	Diabetes	YES/NO
Migraine	YES/NO	Dyslexia	YES/	Hay Fever	YES/NO
Heart/Lung Disorder	YES/NO	Bone/Joint Impairment	YES/	Vision/Hearing Defects	YES/NO
Allergy to Drugs/Food	YES/NO	Gynaecological Disorders	YES/	Ear, Nose & Throat	YES/NO
Gastro-intestinal Disorders	YES/NO	Any Skin Complaint	YES/	Any other medical disorder	YES/NO
Is She / He Vegetarian?	YES/NO	Are contact lens worn	YES/	Special dietary requirements	YES/NO

Please state insulin medication and detail emergency procedure for hypos on the next page

If yes to any of the above, please specify the nature of the problem: .....

.....

.....

Blood Group: ..... Religion (if applicable to Medical Treatment): .....

Are there any other problems of which the Safeguarding Officer should be made aware of? Yes ☐ No ☐ If Yes, please explain:

.....

Does She / He need to carry an adrenaline auto-injector? Yes ☐ No ☐ If Yes, please explain:

.....

What type and does is the adrenaline auto-injector? .....

Does She / He regularly take any form of Medication? Yes ☐ No ☐ If Yes, please explain:

.....

Are there any current injuries/ operations / medical treatments? Yes ☐ No ☐ If Yes, please explain:

.....

Are there any previous operations? e.g., appendix Yes ☐ No ☐ If Yes, please explain:

.....

Has your child received all expected immunisations including tetanus? Yes ☐ No ☐ If NO, please detail what was missed: .....

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Medicines Administration by Member Of Staff Or Member

Whilst my child is away, I authorise you to give the following medicines to my child.

All the medicines specified below have been prescribed by a registered and licensed medical practitioner and will be provided in the original packet / box / bottle with the child's name and date of birth clearly marked. I agree that the medicines are necessary for my child, that they will be given without intending harm to the child and I indemnify The Pony Club or its Branches / Linked Centres against any loss or claim associated whatsoever with the administration of the medicines specified below

Name of medicine	Strength of medicine	How much to give each time	Type (tablet / liquid / inhaler)	When to be given (time of day)	Any other information about this medicine

Paracetamol Yes ☐ No ☐	I authorise the person in charge or their designated deputy to give up to 2 doses of paracetamol or a dosage suitable for the age and weight of my child in a form suitable for my child. I understand that on the administration of the second does I will be contact regardless of the time of the day or night.

MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICINES:
(please note if this box is not completed NO medicines will be given. *Please state if no know allergies*)

Please state if your child carries and takes their own supply of medication:
(e.g. asthma inhalers, contraceptive pills / implants)

Please state insulin medication and detail emergency procedure for hypos:

Other relevant information:

In the event of my daughter/son requiring emergency medical or dental treatment whilst taking part in the Pony Club activity as described above, and an Officer or other responsible adult being unable to contact either myself or other person with a parental responsibility for my daughter/son, I hereby authorise the District Commissioner or other Official of the Pony Club to obtain such medical or dental treatment for my child as they, in their absolute discretion, think necessary after consultation with a medical or dental practitioner. This authority extends to all medical and dental treatment including the giving of an anaesthetic where necessary.

Data provided will be stored in line with current data protection regulations.

Signature: ……

Print Name: …… Date: ……

Role/Relationship: ……