	CHILD PROTECTION MEDICAL INFORMATION	Form WCFCP2 Effective Date 1.10.05. Version 1

Name of Child:

Address:

Post Code:

Date of Birth: Telephone Number:

Please tick Yes or No and complete further details as necessary

Does your child have any specific medical conditions requiring medical treatment and/or medication?

☐ **Yes** If Yes, give details:

☐ **No**

Does your child have any allergies?

☐ **Yes** If Yes, give details:

☐ **No**

Does your child take any medication for asthma?

☐ **Yes** If Yes, give details:

☐ **No**

Any other relevant information

It may be essential at some time for the Club Coach or Team Manager accompanying your son/daughter to have the necessary authority to obtain any urgent treatment which may be required whilst at Club representative competition or training. Would you therefore complete the details on this form and sign below to give your consent.

I, _____ being parent/guardian of the above named child hereby give permission for the Coach or Team Manager to give the immediately necessary authority on my behalf for any medical or surgical treatment recommended by competent medical authorities, where it would be contrary to my son/daughter's interest, in the doctor's medical opinion, for any delay to be incurred by seeking my personal consent.

Signature _____ (consent by parent/guardian)

Print Full Name of Parent/Guardian _____

Date _____