(10) Wight Water Medical Form.

(1)

To be filled in by the Parent or Guardian

Required information – students under 18yrs – schools, groups and individuals

Full Name _____ _____
(Surname) (Forenames)

Start Date_____ Finish Date_____

School / Group Name _____

Note: Whilst at Wight Water your child will be taking part in an adventurous activity which will involve some personal risk. It is a legal requirement that before commencing any activity you fully complete the following medical declaration. The information will us to keep you safe and structure an effective training program for you.

(A). YOUR CHILDS DETAILS

Age_____ Date of Birth_____

Nationally_____

Address_____

_____

Post Code_____ Telephone No_____

Contact no
Parent / Guardian _____ _____
(Business) (Mobile)

Height _____ Weight _____ (Metres)
(Kg)

Would you describe your child as (Please circle as appropriate) Very Fit Fit Unfit Very Unfit

How would you describe yours child's swimming (Please circle as appropriate) Very Strong Water Confident Swimmer Poor

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(B) PARENT CONTACTS who should we contact in case of an emergency? (Please give 2 contacts)

Name_____ Name_____
(Forename) (Surname) (Forename) (Surname)

Relationship_____ Relationship_____
(Parent / Guardian) (Parent / Guardian)

Address_____ Address_____

_____ _____
(Post code) (Post code)

Telephone: home (inc full STD & International code) Telephone: home (inc full STD & International code)

Work / Mobile Work / Mobile

(C) YOUR CHILDS DOCTOR

Name of Doctor_____

Name of Surery_____

Surgery Address and details_____

Post Code _____ Telephone_____
(including full STD and International code)

To be filled in by Parent or Guardian (2)

(D) YOUR CHILDS CURRENT HEALTH

1.Has your doctor prescribed any medication during the last 3 months

If yes please give details

2.TREATMENT AND MEDICATION
Are they currently receiving treatment or taking medication for any of the following

(a) Heart Condition	Yes / No
(b) Diabetes	Yes / No
(c) Epilepsy	Yes / No

3.Hearing

(a) Do they suffer from any deficiency or impairment with there hearing	Yes / No

4. Sight

(a) Do they suffer from any defect in there vision	Yes / No

1. Muscles and Bones

(a) Do they have any restriction of movement of there joints or limbs	Yes / No
(b) Do they have any other restrictions in their movement (neck or back for example)	Yes / No
(c) Do they suffer from any weakness or re occurring injury to their joints, limbs, back or neck	Yes / No

2. Allergies

(a) Do they suffer from allergies	Yes / No
(b) Do they suffer from Asthma	Yes / No

3. Other illnesses or diseases, impairments, and afflictions

(a) Do you have any other illness, disability, or medical condition not included above	Yes / No

4. If you have answered yes to any of the above questions 1 – 8 please give details below

(E) YOUR CHILDS MEDICAL HISTORY

2. You should include below any other medical facts that could effect his or her training or safety during their time at Wight Water. (Please include dietary requirements or previous injuries)

(F) DECLARATION
I declare that the information given above is accurate and true, and that I have not knowingly withheld any information.
I understand that to knowingly withhold information could result in the termination of my child's training at Wight Water without refund.

Signed _____ Date _____
(Parent / Guardian)

Please Print your name_____

Internal use only

Internal Risk Assessment required Yes / NO

(11) Wight Water Medical Form.

(1)

Medical Information required for students over 18yrs

Full Name _____ _____
(Surname) (Forenames)

Start Date_____ Finish Date _____

Course details _____

Note: Whilst at Wight Water your child will be taking part in an adventurous activity which will involve some personal risk. It is a legal requirement that before commencing any activity you fully complete the following medical declaration. The information will us to keep you safe and structure an effective training program for you.
NB. Failure to declare full information will result in the termination of your course without refund.

(A). YOUR PERSONAL DETAILS

Age_____ Date of Birth_____

Nationally_____ Place of Birth_____

Marital Status_____ Passport no_____

Address_____

_____

Post Code_____ Telephone No_____

Contact no _____ _____
(Business) (Mobile)

Height _____ Weight _____ (Metres)
(Kg)

Would you describe yourself as (Please circle as appropriate)	Very Fit	Fit	Unfit	Very Unfit
How would you describe your swimming ability (Please circle as appropriate)	Very Strong	Water Confident		Poor Swimmer
I am (Please circle as appropriate)	Smoker	Non Smoker		

(B) NEXT OF KIN who should we contact in case of an emergency? (Please give 2 contacts)

Name_____ Name_____
(Forename) (Surname) (Forename) (Surname)

Relationship_____ Relationship_____
(Parent / Guardian) (Parent / Guardian)

Address_____ Address_____

_____
(Post code) (Post code)

Telephone: home (inc full STD & International code) Telephone: home (inc full STD & International code)

Work / Mobile_____ Work / Mobile_____

(C) YOUR DOCTOR

Name of Doctor_____

Name of Surery_____

Surgery Address and details_____

Post Code _____ Telephone_____
(including full STD and International code)

(D) YOU'RE CURRENT HEALTH

1.Has your doctor prescribed any medication during the last 3 months
If yes please give details

2.TREATMENT AND MEDICATION
Are you currently receiving treatment or taking medication for any of the following

(a) Depression or other mental or nervous problem	Yes / No
(b) Heart Condition	Yes / No
(c) Diabetes	Yes / No
(d) Epilepsy	Yes / No

3.Hearing

(a) Do you suffer from any deficiency or impairment with there hearing	Yes / No

4. Sight

(a) Do you suffer from any defect in there vision	Yes / No
(b) Do you suffer from any defect in your colour vision	Yes / No

5.Muscles and Bones

(a) Do you have any restriction of movement of there joints or limbs	Yes / No
(b) Do you have any other restrictions in their movement (neck or back for example)	Yes / No
(c) Do you suffer from any weakness or re occurring injury to their joints, limbs, back or neck	Yes / No

1. Allergies

(a) Do you suffer from allergies	Yes / No
(b) Do you suffer from Asthma	Yes / No

2. Learning Difficulties

(a) Are you dyslexic	Yes / No
(b) Do you suffer from any learning difficulty	Yes / No

3. Other illnesses or diseases, impairments, and afflictions

(a) Do you have any other illness, disability, or medical condition not included above	Yes / No

4. **If you have answered yes** to any of the above questions 1 – 9 please give details below

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(E) YOUR MEDICAL HISTORY
1. Have you ever suffered from or received treatment for any of the following

(a) Depression / mental illness	Yes / No
(b) Heart Condition (Heart surgery / heart rhythm / disease of heart or arteries / blood pressure	Yes / No
(c) Stroke or unexplained loss of consciousness	Yes / No
(d) Severe head injury with continuing after effects or major brain surgery	Yes / No
(e) Parkinsons Disease or Multiple Sclerosis	Yes / No
(f) Diabetes	Yes / No
(g) Epilepsy	Yes / No
(h) Alcohol or drug addiction	Yes / No

2. You should include below any other medical facts that could effect his or her training or safety during their time at Wight Water. (Please include dietary requirements or previous injuries)

3. Are there any medical facts that you feel unable to include on this form but would prefer to discuss with a member of staff
Yes / No

(F) DECLARATION
I declare that the information given above is accurate and true, and that I have not knowingly withheld any information.
I understand that to knowingly withhold information could result in the termination of my training at Wight Water without refund.
Signed _____ Date _____
(Parent / Guardian)

Please Print your name_____
_____

Internal use only
Checked By
Signed_____ Date _____
Internal Risk Assessment required Yes / NO