THE CAMPING AND AND CARAVANNING CLUB

CONFIDENTIAL

EMERGENCY MEDICAL TREATMENT CONSENT FORM/
CONSENT TO CAMP FORM

The completion of PART A of this form will give authority to the Youth Leader, or Party Leader, to sign on your behalf any papers needed by a doctor or medical authority in the event of your son, daughter, ward or child for whom you have parental responsibility requiring emergency medical/hospital treatment.

Name .... **Membership No. :** ....

PART A – must be completed by all parents or guardians whose children are not yet 16 years of age.

PART B – must be completed by all parents or guardians whose children intend to take part in Camping and Caravanning Club CCY events

---

PART A – only required for members who are not yet 16 years of age.

I, ... (FORENAMES)

.... (SURNAME)

of (ADDRESS) ....

....

.... Telephone: ....

the Parent/Guardian of (Youth's name) ....

.... authorise the Camping and Caravanning Club's Youth Leader or Party Leader, to sign on my behalf any written consent form for medical treatment required by a doctor, surgeon or other medical authority, if the delay required in obtaining my signature is considered inadvisable by the doctor or surgeon concerned.

I have inserted overleaf Medical Data which is to the best of my knowledge accurate and which I understand may be taken into account for the purpose of deciding whether or not to consent to emergency treatment.

Signed .... Date ....

This authorisation terminates on 31st December of the year dated above.
Any changes to the information provided on this form must be notified to the Youth Leader.

PART B

I authorise my son/daughter/ward to take part in and camp at any authorised event of the Camping and Caravanning Club, during the year ending 31st December, 20 ....

Dated .... 20 .... Signed ....

CONFIDENTIAL

MEDICAL DATA

(please complete in BLOCK CAPITALS)

YOUTH'S NAME ....

DATE OF BIRTH ....

NAME OF FAMILY DOCTOR ....

ADDRESS & TELEPHONE NO. OF DOCTOR ....

....

....

....

.... TELEPHONE ....

NATIONAL HEALTH NO ....

DATE OF LAST ANTI-TETANUS ....

DOES HE/SHE SUFFER FROM ASTHMA, DIABETES, EPILEPTIC FITS OR ANY OTHER ILLNESS OR DISABILITY?
IF SO, PLEASE GIVE DETAILS:

....

....

....

IS HE/SHE ALLERGIC TO ANY MEDICATION..

HAS HE/SHE ANY OTHER ALLERGIES (please give details):

....

....

IS HE/SHE UNDERGOING MEDICAL TREATMENT (please give details):

....

....

....

....

....

....

(FORM REVISED 2005)