WILTSHIRE SCHOOLS' ATHLETIC ASSOCIATION:

Medical & Consent Form: SW Schools XC and Nationals Championship 2024

IMPORTANT: This form must be completed by the parent or Guardian if participant is under 18 Years of age and by the participant if he/she is over 18 years of age

Name of Participant	Male / Female
Address of Participant Post Code	Telephone (incl. STD) Participant's Date of Birth
Next of Kin – Name: Address: Post Code:	Next of Kin Telephone No. (incl. STD) Home: Work: Email:

CONTACT FOR DOCTOR Name: Address: Post Code:	Telephone No.(Incl. STD)

Please give details of any medical Conditions, Disabilities or Allergies to any medication. Please Include any relevant past history	Please give details of any current Medical treatment or Medication.	Details of any Special Dietary Requirements.

I ACKNOWLEDGE RECEIPT OF AND UNDERSTAND THE INFORMATION REGARDING THE PROPOSED SW and NATIONAL XC CHAMPIONSHIPS AND CONSENT TO: .....PARTICIPATING

I have ensured that I/My Child understand(s) the information for My/His /Her safety and for the safety of the group
I undertake to inform the Leader of any changes in the fitness of Myself/the Participant prior to the date of departure.
I am in agreement that those in charge may give permission for Me / the Participant to receive medical treatment in an Emergency

SIGNED:.....Parent/Guardian/Participant. Date...../...../.....

I understand that for the safety of the group and myself, I will undertake to abide by the Code of Conduct and obey the rules and instructions of members of staff at all times.

Signature of Participant..... Date...../...../.....