



PARTICIPANTS CONSENT

All information provided will be kept confidential in line with the Data Protection Act 1998 and the Human Rights Act 2000.

YOUNG PERSON'S DETAILS

First Name:		Last Name:	
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth:	
Address:			
		Postcode:	
Telephone Number:			
Mobile Number:			

School/College:			
Are you a member of a sports or activity club?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, which club?			

EMERGENCY CONTACTS

Emergency Contact:		Relationship:	
Telephone Number:			
Mobile Number:			
Alternative Contact:		Relationship:	
Telephone Number:			
Mobile Number:			

MEDICAL INFORMATION

Does your child suffer from any conditions requiring medical treatment?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does your child suffer from any allergies?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is there any other information we need?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Details if answered YES to any of the above:		
Name of Family Doctor:		
Name of Surgery:		
Telephone Number:		

ETHNICITY

Which of the following best describes the young person? (Please tick one box only)

White:

British Irish Any other White background

Mixed:

White & Black Caribbean White & Black African White & Asian
 Any other Mixed background

Asian or Asian British:

Indian Pakistani Bangladeshi
 Any other Asian background

Black or Black British:

Caribbean African Any other Black background
 Chinese Any other ethnic group

DISABILITY

Does the young person consider themselves to have a disability? Yes No

If yes, what is the nature of the impairment?

Physical Impairment Learning Difficulty
 Hearing Impairment Visual Impairment
 Other, please specify: _____

PARENTAL CONSENT (Under 18's)

I give permission for _____ (name of young person)
to take part in RDAA Activities.

Signed: _____ (Parent/guardian/carer)

Print Name: _____ Date: _____

PHOTOGRAPH/VIDEO CONSENT

We occasionally use images of young people for publicity purposes. If you **DO NOT** give permission for photographs/video footage to be taken and used by Reading & District Angling Association, please tick here:
(Please note if left blank we will assume you are happy for us to take and use photographs and video)

EMERGENCY MEDICAL TREATMENT CONSENT

I give my consent that those in charge may give permission for my child to receive medical treatment in an extreme emergency where neither emergency contact has been able to be contacted.

Signed: _____ Date: _____

Print Name: _____ Date: _____