THE DUKE OF EDINBURGH'S AWARD
www.DofE.org

PARENT AND MEDICAL CONSENT FORM

Name of participant .....

Address .....

..... Post Code.....

Tel. Number – Home ..... work.....

E mail .....

Please provide the following information which will help us should there be any difficulties.

a. Does he/she suffer from asthma, hayfever, migraine, fits or faints, bad period pains, an unusual susceptibility to infections or any other illness or disability? **Yes /No.** If Yes, give details.

b. Is he/she allergic to anything (eg. Antibiotics, elastoplast, aspirin or any other such medicines, any particular foods, etc. **Yes /No.** If Yes, give details.

c. Is he/she receiving medical/surgical treatment at present, (or recently)? (Please notify any changes).
Yes /No. If Yes, give details of last illness/disability and treatment.

d. Can he/she swim? **Yes /No.**

e. Name, address and tel. Number of Young Person's Doctor:.....

.....

f. His/Her National Health number:.....

g. Does he/she have any special dietary requirements? **Yes /No.** If Yes, give details.

I am willing for the above named person to participate in the Duke of Edinburgh's Award and to take part in any activities that may be of a hazardous nature but which fall within the criteria and principles as laid down by The Duke of Edinburgh's Award Handbook.

I also sign to agree that the person named above on the form will abide by reasonable standards of behaviour while undertaking this Duke of Edinburgh's Award activity.

In the event of illness or accident requiring emergency hospital treatment of the above named person, I authorise the Award Group Leader or an agent on their behalf, to sign on my behalf, any written forms of consent required by the hospital authorities, if the delay to obtain my signature is considered inadvisable by the doctor or surgeon concerned.

Name of Parent/Guardian (please print).....

Signed: ..... Date:.....