



MEDICAL AND CONSENT FORM

PLEASE COMPLETE AND RETURN '

Name of Student	I. General Information	Telephone Number
Date of Birth		
Name of Course		
Date of Visit: From To: Evening Telephone Number		
FromTo:		
Address if different 2. Medical Information (please answer all questions as fully as possible. Use reverse of this form if necessary) Do you have any illness, injury or disability? Yes No Give details of any particular dietary requirements: If yes, give details Have you suffered from epilepsy? Yes No Give details of any allergies e.g. medicines, food, animals or m If yes, give details of severity and frequency Have you suffered from asthma? Yes No Date Name & Address of your Doctor Are you currently receiving medical treatment? Yes No Date Name & Address of your Doctor Telephone Number 3. Consent I understand that during the period of my stay abroad, if I am taken ill or injured to the extent that some medication or surgery is required, I authorise the leader of the group or the duty member of staff to sign on my behalf any form of consent which may be required, I authorise the leader of the group or the duty member of staff to sign on my behalf any form of consent which may be required.		
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Signed(Sign & Print) Date	required, I authorise the leader of the group or the duty mem	ber of staff to sign on my behalf any form of consent which may be required
	Signed	(Sign & Print) Date
IF THE STUDENT IS UNDER THE AGE OF 18, THIS MUST ALSO BE SIGNED BY THE PARENT OR GUARDIAN	IF THE STUDENT IS UNDER THE AGE OF 18, TH	HIS MUST ALSO BE SIGNED BY THE PARENT OR GUARDIAN
Signed (Sign & Print) Date	Signed	(Sign & Print) Date