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**Medical Consent and Information Form**

**Student/player personal information**

|  |  |
| --- | --- |
| Full Name |  |
| Date of Birth |  |
| Nationality |  |
| Address |  |
| Phone |  |
| Email |  |

**Emergency contact**

|  |  |
| --- | --- |
| Full Name |  |
| Address |  |
| Phone |  |
| Email |  |
| Relationship to student/player |  |

**Medical history**

|  |  |
| --- | --- |
| Known medical conditions |  |
| Allergies |  |
| Medications currently taking |  |
| Recent injuries or surgeries |  |
| History of concussions or head injuries |  |

**Additional information**

|  |  |
| --- | --- |
| Dietary requirements |  |
| Please include any other information that is relevant |  |

**Consent,** please complete

|  |  |
| --- | --- |
| Consent to participate in physical activity |  |
| Consent for emergency medical treatment |  |

***Please return to: info@first-xi.uk***

**Declaration**

By submitting this form, I confirm that the information provided is accurate.

Signature:

Print name:

Date: