Medical Consent Form

Name of Event: _____

This form is to be completed by the Member if over 18, or the person with parental responsibility for the Member.

Date of event from: _____ to: _____

Name of Member: _____ Date of Birth: _____

Name of Parent/Gaurdian(s)/Next of Kin: _____

Phone(s): _____ Email: _____

Authorised contact if Parents/Guardian/Next of Kin unavailable: _____

Phone(s): _____

Member's GP: Name/Address: _____ Phone: _____

Do they have any of the following:

Asthma	Yes	☐	No	☐	Digestive condtion	Yes	☐	No ☐
Migraine	Yes	☐	No	☐	Gynaecological condtition	Yes	☐	No ☐
Epilsepy	Yes	☐	No	☐	Bone/joint condition	Yes	☐	No ☐
Diabetes	Yes	☐	No	☐	Skin condition	Yes	☐	No ☐
Hay Fever	Yes	☐	No	☐	Ear, nose, throat condtion	Yes	☐	No ☐
Blind or low Vision*	Yes	☐	No	☐	Heart/Lung condition	Yes	☐	No ☐
Deaf or hard of hearing*	Yes	☐	No	☐	Any other medical condition	Yes	☐	No ☐

If yes to any of the above, please explain:

*Are glasses/contact lenses/hearing aids worn, pls specify: _____

Do they have braces/ retainers, or anything that could be dislodged inside the mouth?: Yes ☐ No ☐

If yes, please explain: _____

Do they have any existing injuries/ medical conditions? Yes ☐ No ☐ If yes, please explain:

Do they have any previous operations/injuries e.g .Appendix Yes ☐ No ☐ If yes, please explain:

Have they had all expected immunisations inc. Tetanus? Yes ☐ No ☐ if no, what was missed?

Allergies (e.g medicines, food, plasters, stings etc.) Yes ☐ No ☐ if yes, please state what:

Any dietry requirements: _____

Religion if applicable to diet and medical treatment: _____

Notes: _____

Medicines Administration by Member or by Nominated Person

Do they take regular medication? Yes ☐ No ☐

All the medicines specified below have been prescribed by a registered and licensed medical practitioner and will be provided in the original packet / box / bottle with the recipients's name and date of birth clearly marked. I agree that the medicines are necessary, that they will be given without intending harm, and I indemnify The Pony Club or its Branches against any loss or claim associated whatsoever with the administration of the medicines specified below.

I authorise you to give the following medicines (see below):

Name of medicine	Dosage of medicine	Type tablet/liquid/inhaler	Time(s) of day to be given	Any other information

Do you/they carry an adrenaline auto-injector Yes ☐ No ☐ Reason: _____

What type and dose is the auto-injector? _____

Please state if the Member carries and takes their own supply of medication e.g. asthma inhalers, contraceptive pills.

Paracetamol : I authorise the person in charge or their designated deputy to give up to 2 doses of paracetamol of a dosage suitable for the age and weight of the Member in a suitable form. I understand that on the administration of the second dose I will be contacted regardless of the time of day or night.

Do you authorsie the above use of Paracetamol for the Member?: Yes ☐ No ☐

In the event of the Member requiring emergency medical or dental treatment whilst taking part in The Pony Club activity as described above, and an officer or other responsible adult being unable to contact either myself or other person with a parental responsibility or the next of kin, I hereby authorise the nominated official of The Pony Club to obtain such medical or dental treatment as they, in their absolute discretion, think necessary after consultation with a medical or dental practitioner. This authority extends to all medical and dental treatment including the giving of an anaesthetic where necessary. Data provided will be stored and used in line with current data protection regulations.

I agree to the above authorisation : Yes ☐ No ☐

Does the Member have any learning, processing or special educational needs that we can support them with?

Yes ☐ No ☐ If yes, please explain: _____

Does the Member have any reasonable adjustments in place with The Pony Club?

Yes ☐ No ☐ If yes, please explain: _____

Is there anything that the safeguarding officer should be made awarte of? Yes ☐ No ☐

Please tell us anything else you would like to share regarding the Member, including any worries or concerns you, or they, might have. Please let us know if you would like someone to contact you to discuss this in more detail.

Signature: _____ Date: _____

Print Name: _____ Role/Relationship: _____