

**CONSENT – MEDICAL – CONTACT FORM**

Name:..... Date of Birth: Male/Female

**EMERGENCY CONTACT DETAILS**

Please give details of a responsible person, parent or relative who can be contacted should the need arise.

<b>Name:</b>	<b>Relationship:</b>
<b>Address:</b>	<b>Day Telephone No:</b>
	<b>Evening Telephone No:</b>

<b>Name:</b>	<b>Relationship:</b>
<b>Address:</b>	<b>Day Telephone No:</b>
	<b>Evening telephone No:</b>

**DOES THE YOUNG PERSON SUFFER FROM ANY MEDICAL CONDITIONS YOU THINK WE SHOULD KNOW ABOUT?**

**IF SO PLEASE FILL IN THE SECTION BELOW:**

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**DECLARATION**

**Must be signed by the person with legal responsibility.**

**I agree to son/daughter/young person receiving emergency medical and dental treatment, including anaesthetics, considered necessary by the medical authorities present.**

**Signed:** (parent/guardian)