



East Invicta Amateur Swimming Association

Affiliated to Southern Counties A.S.A., Kent County A.S.A.
R.L.S.S. (Kent Branch)

Reply to :-

REQUEST FOR MEDICATION TO BE GIVEN – East Invicta eXcel Activities **Sep 1st 2011 – August 31st, 2012**

Please make sure you send all medication your child might require on the trip, ***even paracetamol!*** We cannot give any medication without your written consent. **Please do not** give your child their own medication, as they sometimes try to help their friends and there is a danger of being overdosed. We will ask children found to have medicine other than Asthma pumps in their possession to hand it over for safekeeping.

NAME OF CHILD _____

NAME OF MEDICINE _____

PRESCRIBED FOR (condition) _____

AMOUNT TO BE GIVEN _____ TIMES TO BE GIVEN _____

I hereby give my consent for a member of the East Invicta ASA Support Team to administer the above medication on my behalf

Signed: _____ Dated _____

To be completed when medication given.

<u>DATE</u>	<u>TIME</u>	<u>NAME OF MEDICINE</u>	<u>DOS AGE</u>	<u>SIGNATURE</u>

HEALTH QUESTIONNAIRE & MEDICAL CONSENT FORM

SWIMMER'S NAME		
ADDRESS		
TELEPHONE NUMBER	HOME _____	WORK _____
	MOBILE _____	
DATE OF BIRTH		
GP NAME	GP TEL. NUMBER	
GP ADDRESS		
LAST TETANUS	LAST POLIO VACCINATION	
	DATE OF	CONTACT WITH ANY INFECTIOUS DISEASE
ANY ALLERGIES	TO DRUGS or Anything else (nuts, plasters etc)	
ANY CURRENT MEDICATION		
ASTHMATIC	YES /NO (name of medication to remain with child)	

ANY OTHER RELEVANT INFORMATION (bed wetting etc)

It may be necessary at some time for the Club Coach, Team Manager or Club First Aider accompanying your son/daughter to have the necessary authority to obtain urgent treatment which may be required during competition or training. Would you therefore complete the details on this form and sign below to give your consent.

I,.....being the parent/guardian of the above named child hereby give permission for the Coach, Team Manager or First Aider to give the immediately necessary authority on my behalf for any medical or surgical treatment recommended by competent medical authorities, where it would be contrary to my son/ daughter's interest, in the doctors medical opinion, for any delay to be incurred by seeking my personal consent

SIGNATURE.....(parent/guardian)

PLEASE Print NAME..... DATE.....