



## Medical Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Email address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relations to Participant: \_\_\_\_\_

Emergency Contact Tel No: \_\_\_\_\_ Mob: \_\_\_\_\_

Does the individual suffer from any medical condition?

---

Please give details of any current medical treatment?

Has the individual been vaccinated against tetanus in the past 3 years? Y / N \_\_\_\_\_

Please give details of any allergies: \_\_\_\_\_

Please give details of anything that could prevent the individual from participating in a outdoor activity?

Name of Doctor: \_\_\_\_\_ Doctor's Telephone No: \_\_\_\_\_

Please tell us about any special dietary requirements? (e.g. Vegetarian, nut allergy)

**I CAN / CANNOT SWIM** (for information only, it is not a necessity and buoyance aids will be provided)

**I DO / DO NOT** agree to Carrowmena taking photographs as a means of promoting their business through displays, presentation, social networking sites and website.

### Acceptance of Responsibility

We supply qualified staff and specialist equipment, but all outdoor activities contain inherent risks. I agree and understand that I participate entirely at my own risk and I declare I have no medical/ physical conditions that would preclude me from taking part. I consent to any emergency medical treatment necessary in the event of an accident

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

### Parent/Guardian Permission

Participants under the age of 18 years must have signed consent from a parent/Guardian (sign below)

NAME: \_\_\_\_\_ SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

---

100 Carrowclare Rd, Limavady, Co.L/Derry BT49 9EB

Tel: 028 7776 3431 Email: [info@carrowmena.co.uk](mailto:info@carrowmena.co.uk) [www.carrowmena.co.uk](http://www.carrowmena.co.uk)