



BOOKING/CONSENT FORM- CONFIDENTIAL

Please return to: **Summer Sensations** c/o Atlantis Leisure, Dalriach Road, Oban, Argyll, PA34 5JE

Information provided by you will be used by Summer Sensations and its partners for the purposes of the activity programme only. Please read the booking conditions then complete in **BLOCK CAPITALS**. Please complete **ONE FORM PER PARTICIPANT**.

Participants Details

Surname:

First Name:

Date of Birth: Age:

Primary school your child attends / attended:

Address:

.....

.....

Postcode:

Telephone:

Email:

Next of Kin:

Does the participant suffer from any medical or special needs condition that may affect their ability to participate in the activity? YES/NO
If YES, please give details:

Has the participant received a tetanus injection in the past 5 years? YES/NO

Is the participant currently taking any medication? YES/NO

If YES, please give details including name, dosage and frequency:

Will the medication be self-administered? YES/NO
(Please note: If the participant requires medication during the timescale of the activity but fails to bring it on the activity, they will not be allowed to participate)

Is the participant allergic to any medication/substance? YES/NO

If YES, please give details:

Has the participant suffered from or been in contact with any infectious/contagious disease within the last three months? YES/NO

If YES, please give details:

Activity Details

SS2011	Course Name	Date	Cost
	Summer Sensations 2011	11&12/8/11	£25.00 / 1 child £40.00 / 2 children £5.00 (see letter)

Please give details of any previous experience of the activity the participant has had. If none, write none:

Photographs may be taken of participants by the Summer Sensations organising committee for promotional use. No person will be named. If you do not wish to be included, please write to the above address.

I enclose a cheque made payable to **Atlantis Leisure** for full payment of the programme booked: £.....

Name of Doctor:

Surgery Address:

Surgery Telephone:

State any special dietary requirements:

Do we have permission to administer the following:

1. Paracetamol? YES/NO
2. Anti-septic wipes/cream? YES/NO
3. Sun protection cream? YES/NO

Emergency Contact Details

Please provide details of **two** contacts that can be used during the timescale of the event.

Name of emergency contact:

Address:

Telephone: (Home)

(Work)(Mobile)

Alternative Emergency Contact

Name:

Address:

Telephone: (Home)

(Work)(Mobile).....

Consent

I consent to my son's/daughter's participation in the activities.

To the best of my knowledge my son/daughter is medically fit to participate in the activities. I undertake to Atlantis Leisure in the event of any change in fitness or health that may take place prior to the activities.

I agree to my son/daughter receiving emergency medical, surgical and dental treatment as considered necessary by the medical authorities present.

I understand that if my son's/daughter's behaviour jeopardises their own safety or the safety of others, he/she may be removed from the activity and any additional costs incurred as a result of his/her actions may be recovered from me.

Name:

(Parent/Guardian)

Signed: **Date:**

Opt out:

I do NOT wish for my child to participate in the outdoor Stramash activities:
Signed: **Date:**

I do NOT wish for my child to participate in the Oban Youth Café activity:
Signed: **Date:**

Medical Information

(Please note: we cannot be held responsible for the consequences of non-disclosure of information.)

Does your child require additional support in school? Yes / No and if so please provide details: