

STOURBRIDGE JUNIORS FIRST AID TREATMENT

CONSENT FORM

Name of Child ............................................

Date of Birth ............................................

Name of Parent/Guardian ...........................................

Address .............................................................................................................

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Emergency Telephone No ...........................................

Mobile No ...........................................

Email Address ...........................................

In the event that my son/daughter is injured whilst playing football/travelling to and from football event’s, I hereby give my consent for an appointed person of Stourbridge Youth Team ( U ...........’s) Football Team to provide first aid assistance/treatment to my child.

Does your child suffer from any medical conditions/allergies that the club/coach should be aware of?

Eg . Diabetes, asthma, epilepsy

Yes / No

If yes please provide details of medication that must be administered:- .................................

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Signed: ....................................................... Date: .................................