

CONFIDENTIAL Information on Members / Associates attending Pony Club Camps, Courses or Visits

This form is to be completed by the Parent / Guardian of each Pony Club Member.

Date of Camp / Course / Visit From _____ to _____

PC BRANCH _____

Name of Member / Associate _____ Date of Birth _____

Name of Parents / Guardian _____

Authorised contact
if parent unattainable _____ Tel. No. _____

Address of Parents / Guardian _____

Tel. Number (Day) _____ (Night) _____

Fax Number _____ Email _____

Member's General Practitioner – Name: _____

NAME & ADDRESS OF PRACTICE: _____

_____ Postcode: _____

Does he / she suffer from:

- * Asthma YES / NO * Epilepsy / Fainting YES / NO
- * Migraine YES / NO * Diabetes YES / NO
- * Dyslexia YES / NO * Hay Fever YES / NO
- * Heart / Lung Disorder YES / NO * Bone / Joint Impairment YES / NO
- * Vision / Hearing Defects YES / NO * Allergy to Drugs / Food YES / NO
- * Gynaecological Disorders YES / NO * Ear, Nose & Throat YES / NO
- * Gastro-intestinal Disorders YES / NO * Any skin complaint YES / NO

Are contact lens worn? _____ Religion, if applicable to Medical Treatment _____

Any other problem of which the Welfare Officer should be aware? _____

Does he / she regularly take any form of Medication, if so what? _____

Are there any current injuries / recent operations / medical treatments? YES / NO If so, please explain.

Any previous operations, e.g., appendix YES / NO If so, please explain

Date of last Tetanus Injection _____ (Any adverse reaction?)

Blood Group (if known) _____ Is he / she a Vegetarian YES / NO

Does he / she have any special dietary or other requirements? _____

In the event of my daughter/son requiring emergency medical or dental treatment whilst taking part in the Pony Club activity as described above, and an Officer or other responsible adult being unable to contact either myself or other person with a parental responsibility for my daughter/son, I hereby authorise the District Commissioner or other Officer of the Pony Club to obtain such medical or dental treatment for my child as they, in their absolute discretion, think necessary after consultation with a medical or dental practitioner. This authority extends to all medical and dental treatment including the giving of an anaesthetic where necessary.

Signed _____ Date _____