

Outdoor Activities

Adult Consent/Medical Form

FALKIRK COUNCIL



| | | | |
|---------------|--|-----------|--|
| Name | | Address | |
| Date of Birth | | | |
| Telephone | | | |
| Mobile | | Post Code | |
| E-Mail | | | |

Emergency Contact Details

| | | |
|--------------|--|------------------------|
| Name | | Emergency Contact No's |
| | | 1. |
| Relationship | | 2. |
| E-Mail | | |

Are there any medical conditions that the Outdoor Instructor should be made aware of. This information should include asthma, allergies or injuries, if yes please provide details.

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I hereby grant permission for emergency medical treatment or medication to be administered to me by on-site first aiders or qualified medical respondents in the event of an accident:

Yes No

During the activity session photographs and video may be taken and used for publicity to promote Falkirk Council Outdoors in print and online including social media.

I agree for photographs and video to be taken.

Yes No

| | | | |
|------|--|--------|--|
| Name | | Signed | |
|------|--|--------|--|

Please complete this form and return it to the outdoor centre.