

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.

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