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 _____

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 _____

_____

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 _____