

ADHD SOLUTIONS PARENTAL CONSENT AND MEDICAL FORM



Please complete this form as fully as possible. The information may be held on computer and will be used to contact you if necessary. It will also be helpful to ADHD Solutions in ensuring our services meet your needs.

Name of Activity: Various Activities

Times / Dates: Various throughout 2018

Details of Child / Young Person:	Female <input type="checkbox"/>	Male <input type="checkbox"/>
Name	_____	
Address:	_____	
Postcode:	_____	
Tel No: Daytime:	_____	Evening: _____
D.O.B:	_____	
Name of: Parent/Guardian/Carer	_____	
Address (* if different):	_____	
Membership No:	_____	

Please Note: It is parents/carers responsibility to inform ADHD Solutions of any changes to this form in the next year i.e: mobile number, address or medical condition. ADHD Solutions are unable to take responsibility if information is not up to date.

Does your child/young person have special needs (e.g. ADHD)? Yes: No:

I give permission for my child / young persons' photograph / voice/ video to be used by ADHD Solutions for development and publicity purposes: Yes: No:

DATA PROTECTION

The personal data collected on this form will only be used for the purpose of processing your child's registration. It is required for various administrative and health and safety reasons. In addition, statistical information will be shared with Funding Bodies and the Government for monitoring purposes

As some of the personal data we have collected on this form is deemed 'sensitive' under the Data Protection Act 1998 your written consent is required.

You can provide that consent below. If you are unsure or require further information please contact the centre on 0116 261 0711.

I understand and agree to the processing of my personal data provided on this form according to the terms outlined above.

Signed: _____ **Date:** _____

PLEASE ENSURE YOU RETURN THIS FORM COMPLETED ON BOTH SIDES!

CHILDREN & YOUNG PEOPLE MEDICAL FORM

Please complete this side of the form as fully as possible. The information may be held on computer and will be used to contact you if necessary.

MEDICAL INFORMATION

So that we can offer the best possible service we would like you to answer the following questions.

My child/young person's home doctor's details are:

Name _____ Tel No _____

Address _____ Postcode: _____

Name of contact in emergency if Parent/Guardian/Carer is not available:

Tel No. _____

Does your child/young person:-

a) Have any conditions requiring medical treatment, including medication? YES/NO

If YES, please give details _____

b) Have any special requirements e.g. diet, allergies epilepsy, disabilities, learning difficulties? YES/NO

If YES, please give details _____

c) Is your child/young person allergic to any medication e.g. penicillin? YES/NO

If YES, please give details _____

d) Has your child/young person received a tetanus injection in the last 5 years? YES/NO

If you have answered YES to any of the above questions, it does not mean your child/young person will be excluded from activities but we will be able to offer a better service to your child/young person.

DECLARATIONS

I agree to my son/daughter receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

I understand the extent and limitations of the insurance cover provided.

Signed: _____

Date: _____