



Consent & Medical INFORMATION

www.cycle4adventure.co.uk

Activity Details

| | | |
|--------------------|--|--|
| Activity or course | | |
| Date | Please return completed forms by:- 5.00pm two days prior to first activity session | |
| Activity Venue | Other venue | |

Participant details

| | | |
|--------------------------|--|--|
| Name (participant #1) | Date of Birth | |
| Address | Post code | |
| Contact telephone number | Do you have any medical Conditions (please list below) | |

All participants below MUST live at the same address as participant #1

| | Participant name | Date of Birth | Does the participant have a medical condition (please list below) |
|----------------|------------------|---------------|---|
| Participant #2 | | | |
| Participant #3 | | | |
| Participant #4 | | | |
| Participant #5 | | | |

Emergency Contact Details

| | | | |
|-------------------------|--|-----------------------------|--|
| Name | | Relationship to participant | |
| Address during activity | | Contact telephone number #1 | |
| | | Contact telephone number #2 | |

Medical Details

Any medical conditions, recent illnesses, allergies, surgery, pregnancy or other information the instructor should be aware of

Consent and acknowledgment

Please read the [Statement of Risk Statement](#) and [Terms & Conditions](#)

This section is to be completed by the parent or guardian of the participant, if under the age of 18 years. If participant is over 18 years, please complete for yourself.

We have read and agree with the "Statement of Risk" statement

I confirm that all the information is correct to the best of my knowledge and that I give Consent to the participant taking part in the activity.

Completed by:

parent or guardian / participant over 18

Name

Date

Signature

Details of any medication

Doctors name

Doctors address

Doctors telephone no.