PLEASE COMPLETE FULLY AND IN BLOCK CAPITALS

SURNAME _____

FIRST NAME _____

ADDRESS _____

_____ POST CODE: _____

TELEPHONE _____ MOBILE _____

E-MAIL _____ D.O.B if under 16 _____

EMERGENCY CONTACT(Name): _____

EMERGENCY CONTACT(Number): _____

Medical

Do you take any medicines regularly, or have any allergies, disabilities or medical problems that we should know about? NO/YES: (if YES please give further details on reverse of form)

PLEASE NOTE IT IS YOUR RESPONSIBILITY TO INFORM YOUR INDIVIDUAL INSTRUCTOR OF ANY MEDICAL CONDITION THAT MAY AFFECT YOUR HEALTH WHILST UNDER THEIR INSTRUCTION.

The information declared on this form is used solely within our organisation and is not passed on to anyone. Please sign below to confirm you are happy for us to hold the above data.

Signature _____

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