

Derbyshire School of Rugby Medical and Photograph consent form

Players Name		DOB	
Address			
Postcode			
Tel: Home			
Tel: Mobile			
Email:			
Present Club		Position	

Doctors Name	
Address	
Postcode	
Tel: Home	

<p><u>Please list any relevant medical information</u></p> <p>The following may be useful: - Date of tetanus, any known allergies, blood group, recent x-rays, Religion if medically relevant</p>

In the event of illness or accident requiring emergency treatment, I understand that in my absence of my consent, I authorise the Squad Manager / Head Coach to sign, on my behalf, any written form of consent for treatment deemed necessary by a qualified medical practitioner.

Name of Parent / Guardian: _____

Signed: _____

Date: _____

*NB: All attempts possible will be made to contact parents / guardians in such circumstances. Medical treatments include inoculations, blood transfusions, the use of anaesthetics and surgery.

Photograph consent

I agree for my son **Name** _____ to be photographed and photos used for publicity purposes where applicable.

Name of Parent / Guardian: _____

Signed: _____ **Date** _____

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