



CONFIDENTIAL

Parental Consent Form

Name of Region/ Unit _____

Section _____

I /We and Parent(s) of _____
who was born on the day _____ 20, _____

hereby give permission for my/our child to partake in all activities involving the above Region / Unit / Section during the year commencing 1st September, 20 ____ . I / We hereby appoint the Leaders of the said Region / Unit / Section, including anyone specified in the schedule hereto, as Guardians of our child during the said period.

I / We further authorise, confirm and agree that such Leaders shall have authority over our child and the right to give lawful instructions to our child to the same extent as we, ourselves, would be able so to do. In the event of my /our child being taken ill or injured during the period of this consent, I / We hereby authorise and direct and appoint any one of the Leaders as my / our Attorney for the purpose of giving consent to all and any forms of surgical or medical treatment (including Anesthesia) as they in their absolute discretion shall think fit, and I /We hereby direct all hospitals and medical Institutions to recognise the authority hereby granted. I / We further authorise the Leaders to sign, on our behalf, any written form of consent required for such medical or surgical treatment without necessity for them to contact me / us prior so to doing.

I / We confirm the following medical details in relation to my / our child is correct.

My / Our Child

HAS HAS NOT had a Tetanus Immunisation (if immunisation has been obtained, give details of number and type of injections and dates of booster injections on the reverse of this form.)

IS IS NOT allergic to penicillin.

IS IS NOT able to swim.

HAS HAS NOT my permission to take part in supervised swimming and water sports.

DOES DOES NOT suffer from travel sickness

HAS HAS NOT had rabies inoculation (if inoculated , give date of inoculation and serum type on reverse.)

HAS HAS NOT been in contact with or exposed to an infectious disease.

IS IS NOT HIV positive.

Last had a medical check - up on the _____ day of _____ 20 ____
Is suffering from the following ailments or conditions which require that he / she be kept under observation and / or receive treatment and / or medication on an ongoing basis.

See overleaf for further details

Our family G.P. is Dr _____
of _____
Telephone No. _____

Signature of Parent (s) _____ Date of signature _____

Address of Parent (s) _____

Telephone of Parent (s) Work _____ Home _____

Witness to signature of Parent (s) _____

List of Leaders who are Authorised as above

- | | |
|---------|---------|
| 1 _____ | 2 _____ |
| 3 _____ | 4 _____ |
| 5 _____ | 6 _____ |

N.B. This form is to be returned as soon as possible to Leader and all information given or disclosed will be treated as private and confidential.