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CONSENT, EMERGENCY CONTACT AND MEDICAL INFORMATION FORM

Date: _____ **Squad:** **SWRFC REBELS**

Player Name: ..... **D.O.B:** .....

Address: _____ Tel. Home: _____

_____ Tel. Mob: _____

_____ Email: _____

KIT SIZE REQUIREMENTS

CHEST:_____ WAIST:_____

HEIGHT:_____ SHOE SIZE:_____

NEXT OF KIN:

Name: _____ Relationship: _____

Address:_____ Tel. Home: _____

_____ Tel. Work: _____

_____ Tel. Mob: _____

ALTERNATIVE CONTACT IN AN EMERGENCY

Name: _____ Relationship: _____

Address:_____ Tel. Home: _____

_____ Tel. Work: _____

_____ Tel. Mob: _____

GP NAME: _____ Tel No: _____

Address: _____

_____

_____

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Please either tick no or enter details:

Are you currently taking any medications (including Inhalers) (If you use an inhaler bring it with you)	**Yes/No**	**Details if yes:**
Do you suffer from any allergies? (e.g. food, medication, tapes etc..)	**Yes/No**	**Details if yes:**
Any previous hospital admissions/visits to Specialists?	**Yes/No**	**Details if yes:**
Any serious or recurring injuries? (off rugby for more than 2 weeks)	**Yes/No**	**Details if yes:**
Have you had a Dental check in the last year?	**Yes/No**	**Details if No:**
Any family history of sudden death under 50?	**Yes/No**	**Details if yes:**
Any history of chest pain or palpitations?	**Yes/No**	**Details if yes:**
Ever fainted or passed out when exercising?	**Yes/No**	**Details if yes:**
Are you currently injured?	**Yes/No**	**Details if yes:**
If so, who is treating you and where are they based?		**Details:**
Any other medical problems or specific dietary requirements? (e.g. asthma, epilepsy, diabetes, gluten intolerant, etc)	**Yes/No**	**Details if yes:**
Have you had all your childhood immunisations?	**Yes/No**	
Do you currently take any dietary supplements?	**Yes/No**	**Details if yes:**

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Any strappings, supports, contact lenses or similar items used during training or matches?	**Yes/No**	**Details if yes:**
Do you have Down's Syndrome? **(If no – please go to the declaration and complete your form with signature/s.)**	**Yes/ No**	
Do you want to play Contact Rugby, Touch Rugby or both? **If Touch Rugby only – please go to the declaration and complete your form with signature/s.**		**Contact** | **Touch** | **Both** ***THIS QUESTION MUST BE ANSWERED BY ALL PLAYERS (PARENTS/GUARDIANS WHERE APPLICABLE)***
Have you been tested for Atlantoaxial Instability (AAI) **(condition associated with some people with Down's Syndrome)**	**Yes/No**	
Do you have this condition ***We require a letter from your doctor to confirm this result***	**Yes/No**	**If yes, you will be able to play Touch Rugby only.**

You are required to wear a mouth-guard when training/participating at any SUNDAY'S WELL REBELS squad/match/rugby event, and may be withdrawn if this does not happen.

Any medical information on this form is private and confidential and is only to help us in managing and planning your health care.

Declaration:

I will inform the Medical staff in charge of the team as soon as possible of any change to my medical history or contact details. I hereby consent to receiving first aid and medical treatment and care as appropriate. I also consent for SUNDAY'S WELL REBELS staff to communicate any information of relevance regarding my health and ability to participate in rugby to any party who may reasonably require it in the context of caring for me, or for SUNDAY'S WELL REBELS' business.

Signature of Player:_____ **Date:** _____

Print Name: _____

Parent / Guardian must complete the following:

I consent to _____(Print Player's Name) receiving first aid and medical treatment and care as appropriate, and for their medical information to be used as appropriate in their care. ***I give consent also for _____ to play full contact Rugby Union***.

Signature of Parent / Guardian: _____ **Date:** _____

Print Name:_____

Sunday's Well Rebels
c/o **Sundays Well RFC -** Musgrave Park, Cork
Manager: Mr. Liam Maher **Ph**: 087 2364930 **Email**: liam@sheilashostel.ie
Website: www.sundayswellrfc.com/

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Where medication is required, please complete – Administration of Medicines

Are you allergic to any medication? Yes / No
If Yes, please give details below:

_____

_____

Full Name of Player _____

Nature of illness/medical condition _____

Medication

- Use one section for each different medicine (e.g. 1 Ventolin, 2 Becotide)
- Include emergency medication
- Include any other relevant information (e.g. maximum daily dose)

Name of Medicine	Dosage	Time to be taken
1.		
2.		
3.		

I confirm that the player /parent/guardian will be responsible for the above medicine and that they are able to administer the medicine themselves under supervision only, by a non-medically qualified person.

Signature of Parent/Guardian_____

Date:_____

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Photography / Filming

I give my / the participants permission to be photographed or filmed. I understand that the photos or film may be used at the discretion of Sunday's Well RFC and that these may be published or used for public display at the consent of the individual.

Player:

Signed by: _____

Print Name: _____

Date: _____

Parent / Guardian:

Signed by: _____

Print Name: _____

Date: _____

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