

# Siblings United

## CONSENT – MEDICAL – CONTACT FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male/Female \_\_\_\_\_

### EMERGENCY CONTACT

Please give details of a responsible person, parent or carer who can be contacted should the need arise.

Name:	Relationship:
Address:	Day Telephone No:
	Evening Telephone No:

Name:	Relationship:
Address:	Day Telephone No:
	Evening telephone No:

DOES THE YOUNG PERSON SUFFER FROM ANY MEDICAL CONDITIONS YOU THINK WE SHOULD KNOW ABOUT?

IF SO PLEASE FILL IN THE SECTION BELOW:

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### DECLARATION

Must be signed by the person with legal responsibility for the child.

I agree to \_\_\_\_\_ ( name of child) receiving emergency medical and dental treatment, including anaesthetics, as considered necessary by the medical authorities present.

Signed: \_\_\_\_\_

I am \_\_\_\_\_ ( relationship to child))

**SIGN AND FAX BACK ON 020 8875 1954**