



Parental Consent form

Sailing Training Session Booking Form

Training sessions will be delivered by DWSC in accordance with RYA training centre guidance, and staffed by appropriately qualified and experienced RYA instructors.

Booking Conditions

1. DWSC reserves the right, at all times, to cancel bookings at our discretion.
2. All participants **MUST** be between the ages 8 and 16, wear the buoyancy aid provided and be confident in the water.
3. All children must be accompanied by a parent or guardian at the beginning and end of the session. Parents or guardians must also be contactable (for example by mobile phone) for the duration of the session.
4. Neither DWSC nor any of its employees or agents shall be liable in any way whatsoever in respect of loss or damage to property.
5. DWSC must be informed, at the time of booking, of any medical condition affecting the participant, or of any medication taken by the participant that could affect their taking part in the above sailing session, e.g. asthma, epilepsy, heart conditions. DWSC reserves the right to refuse any booking on medical grounds.
6. All bookings are accepted on the understanding that any instructions or directions given by any member of the centre's staff are to be observed. Participants are asked to respect the equipment provided; compensation will be sought from anyone deliberately causing damage to equipment.
7. DWSC reserves the right at all times to refuse or restrict the use of facilities. The right is also reserved to evict anyone who refuses to comply with the conditions as stipulated, or who behaves inappropriately or, in any way, causes damage or annoyance to any other persons.
8. Participants are to wear suitable clothing and footwear when going on a boat. Suitable footwear means flat soft soled shoes or trainers. Please bring a change of clothing as sailing can be wet.
9. If any injuries are sustained or damage to valuables occurs, participants are to notify the centre's staff immediately.

Participant's First Name: Surname:

Age: (participants must be aged between 8 and 16 yrs) Date of Birth:

Address:

..... Postcode:

Please give details of any disability/medical condition/medication that you think the centre should know about eg. sight/hearing impairment, limited mobility, asthma, diabetes, epilepsy

Declaration: I hereby acknowledge that I have read the above conditions of participation and that I fully understand them. I have explained them to my child, who understands and agrees to abide by them.

Signed by Parent or Guardian: Date:

Print name:

Contact telephone number during session:



Medical consent and emergency contact form

THIS FORM IS DOUBLE SIDED – PLEASE ENSURE YOU TURN OVER
Please complete all sections in Block Capitals

SAILOR DETAILS:

| | |
|----------------|--|
| Sailor Name: | |
| Home Address: | |
| Date of birth: | |
| Age: | |

EMERGENCY CONTACTS:

Emergency Contact

| | |
|----------------|--|
| Name: | |
| Relationship: | |
| Home Number | |
| Work Number | |
| Mobile Number: | |

Alternative Emergency Contact:

| | |
|----------------|--|
| Name: | |
| Relationship: | |
| Home Number | |
| Work Number | |
| Mobile Number: | |

IF DIFFERENT FROM ABOVE:

| | | | |
|-----------------------|--|----------------|--|
| Mother's Name: | | Mobile Number: | |
| Home Number | | Work Number: | |
| Father's Name: | | Mobile Number: | |
| Home Number | | Work Number: | |

DOCTOR DETAILS:

| | | | |
|----------------|--|--------------|--|
| Doctor's Name: | | Work Number: | |
|----------------|--|--------------|--|

It is your responsibility to make known any potential medical conditions that may affect you during the activities associated with the programme you will be taking part in. Please therefore provide as many details as possible. This information will be shared with the organisers and coaches at events and training.

Have you ever suffered from any of the following conditions:

- | | | |
|-----------------------------------|-----|----|
| • Asthma/bronchitis | Yes | No |
| • Heart conditions | Yes | No |
| • Fits, fainting or blackouts | Yes | No |
| • Severe headaches | Yes | No |
| • Diabetes | Yes | No |
| • Travel sickness | Yes | No |
| • Allergies to medication | Yes | No |
| • Any other allergies | Yes | No |
| • Other illnesses or disabilities | Yes | No |

If you have answered yes to any of the above, please provide details in the box below.

When did you last have a tetanus vaccination? Year

Are you currently taking any medication? If so please specify:

Are you suffering/recovering from any injuries which may affect your sailing?

Are you vegetarian? Yes No Do you have any food allergies? If so, please specify:

Consent

I the parent/guardian of give permission to the organisers of activities during the period (dates of event) to administer any relevant treatment or medication to the above-named participant when or if necessary.

In an emergency situation I authorise the organisers to take my son/daughter to hospital and give my full permission for any treatment required to be carried out in accordance with the hospital's diagnosis. I understand that I shall be notified, as soon as possible, of the hospital visit and any treatment given by the hospital.

Signed: (parent/guardian)

Name: (please print) Date: