

**Medical Information/Consent Form**  
**Wellingborough Rugby Club U9's & U10's**

Please complete this form to the best of your knowledge. **All information given will be treated in a confidential manner.**

Child's name .....	(M/F) .....
Date of Birth .....	
Address	
.....	
.....	
.....	
.....	

**Next of Kin Information**

Name of Next of Kin .....
Relationship .....
Telephone Number (Inc mobile) .....
.....
<b>Address of NOK if different than above</b>
.....
.....
.....

**Are there any illnesses/conditions/allergies that we should know about? If so please list them below.**

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**Please give the name & address of GP.**

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**I confirm that the information given is correct to the best of my knowledge and I hereby give consent for the person named above to receive emergency first aid from a qualified person or hospital as required.**

Date:

Signed:

Name:

**Please state relationship if not Next of Kin:**

**Please note that the information provided may be passed onto medical personnel if hospital treatment is required.**