

APPENDIX S

BRITISH TAEKWONDO COUNCIL

MEDICAL TREATMENT PERMISSION FORM

Surname:		First Name:	Known as
Address:			
Date of Birth:		Age:	
Parent/Guardian (1):	Name	Relationship	Contact No
Parent/Guardian (2):	Name	Relationship	Contact No
Child's Doctor:	Name	Address	Contact No
Child's Medical Conditions/Allergies:			
Other Information:	Please give details of any relevant disability, main language or special dietary requirements		
Authorised collection by anyone other than Parent/Guardian above (if relevant):	Name	Address	Contact No

- I give permission for the instructor/coach staff at the event to seek any necessary emergency medical advice or treatment for my child.
- I have read the Fair Play Policy and event details and discussed them with my child.
- I understand that my child will attend the event fromam/pm on and be collected byam/pm on

Signed: Date: