



CONSENT, CONTACT AND MEDICAL FORM

This form must be completed and returned to THE EDGE CLINIC
before any student can be allowed to participate.

Student and Parental Consent

First name		Family name:	
Date of Birth		Form:	

Venue:	Zauchensee, Austria		
Date(s) From		To	

I agree to (my son/daughter) taking part in the forthcoming training programme to Zauchensee, Austria.	Parent or Guardian's signature (If under 18)		

Student Contact Details

Home address			
Contact telephone numbers (for the duration of the training programme)			
Name		Home	
Mobile		Work	

Alternative contact	Relationship to student :		
Address			
Name		Home	
Mobile		Work	

CONTINUED

Registered address: Apartment Strims, Strims 3, Zauchensee - Altenmarkt, 5541, Austria



Medical Information

Name of doctor		Tel no	
Address of surgery			

Please mark with X if appropriate :

I do not suffer from any medical condition requiring regular treatment.	
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I suffer from the following:			
And have been prescribed the following medication	Name of medication	Dose	Frequency

NB: Please ensure you include information relevant to night-time needs

I also uses the following over-the-counter medication	Name of medication	Dose	Frequency

CONTINUED



I have an allergy to the following:	Allergic to	Type of reaction

Please delete as appropriate

I would like to discuss my medical condition with the training organisers	YES NO
I have an up to date tetanus injection.	YES NO
I am willing to be given with “over-the-counter medication” by staff e.g. paracetamol, throat lozenges, plasters, insect bite antihistamine.	YES NO

Any medication required should be given to a member of the SKIACADEMY AUSTRIA staff in charge, clearly marked (in its prescription container if applicable) with name and full instructions for use.

Inhalers and “Epi-pens” may be kept by the student with spares given to a staff member in charge.

Dietary Information

Do you have any special dietary requirements e.g. vegetarian, kosher, allergies	(please give details)	YES NO

CONTINUED



Additional Information

Please include any additional information as required

Declaration (Parent/Guardian for students if under 18)

1. I have read and completed this form and to the best of my knowledge the details given are true and accurate.

2. I agree to my child receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

3. I will inform a member of staff as soon as possible of any changes in the medical or other details between now and the commencement of the training programme.

Signature		Date	
Print Name			