**FORM OSA3 (2016) (ADULTS)**

**Warwickshire County Council – Consent to Activity, Medical Details and Treatment Form**

Name of Adult: ..................................................................................................................................

Date of Birth: ............................................................... Male  Female

Home address: .................................................................................................................................

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Telephone Number: .........................................................................................................................

Visit to: ..............................................................................................................................................

From: ........................................................ (Date) To: ......................................................... (Date)

Name of Education Establishment: ..................................................................................................

Names and telephone numbers of emergency contacts:

1. ...............................................................................................................................................
2. ...............................................................................................................................................

Name, address and telephone number of own doctor (GP)

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Are you allergic to anything? (e.g. Aspirin, antibiotics, any particular food or drug?)

If so, please give details:

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Do you suffer from any illness or disability? If so, please give details:

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………................................................................................................................................................

Are you having any medical treatment at present? If so, please give written details of treatment and medicines, etc.

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Are there any activities in which you should not participate? ..........................................................

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Date of anti-tetanus injection (if known): .........................................................................................

Is there any other information which the Party Leader should be aware of?

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………...............................................................................................................................................

Name/Please Print: ………................................................................................................................

Signature: ............................................................................... Date: ................................................