MEDWAY OPEN AWARD CENTRE

Medway Open Award Centre

DUKE OF EDINBURGH'S AWARD

CONSENT FORM

Please print clearly in **CAPITALS**. You must complete all fields/questions.

PERSONAL DETAILS – PRINT CLEARLY IN CAPITALS					
First Name(s)				Home Address	
Last Name					
Date of Birth	DD/MM/YYYY	Age			
Gender				County	
Language	English		Other	Post Code	
Email				Parent Email	
eDofE number				Contact No)	

Enrolment Level:	Bronze		Silver		Gold	

Participant Declaration (signed by participant)**:**

I agree to enrol as a participant on a DofE training and expedition programme run by MOAC. I understand that I will be required to attend all training sessions and meet all deadlines. I understand that I can be removed from the programme if my behaviour is deemed unacceptable.

Print Name: …… Signature: …… Date: DD/MM/YYYY

Emergency Contact Information (participant's next of kin)			
First Name(s)		Home Address	
Last Name			
Email		Town/City	
Relationship to participant		County	
		Post Code	
Contact No (home)		Contact No (mob)	

Medical Information (relating to the participant)		
Has s/he been in contact with any contagious or infectious disease within the last four weeks?	YES	NO
Is s/he allergic to anything? (e.g. aspirin, antibiotics, foods, or drugs)	YES	NO
Does s/he suffer from any illness or disability? (e.g. asthma, diabetes, or hay fever)	YES	NO
Is s/he having any medical treatment at present?	YES	NO
Is there any other current or previous condition/medical history that might affect her/his participation in these activities?	YES	NO
If you have answered yes to any of the above, please give details here;		

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Declaration of Consent

I am willing to allow my self/son/daughter/ward to participate in the DofE expedition programme.

I agree to Medway Open Award Centre contacting my self/son/daughter/ward by phone, email, or social media in reference to the expeditions programme.

I agree to notify the office of any changes to the details given above as soon as possible.

I agree to my self/son/daughter/ward receving medication as instructed and any emergency dental, medical, or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorites present.

MOAC may use images of participants for display and advertising purposes.
If you AGREE to pictures of yourself/your child/your ward to be used, please tick here. ☐

Print Name: …… Signature: …… Date: DD/MM/YYYY
(signed by parent, guardian, or participant if over 18)

Any further information, please continue here;