

The Choi Foundation Brighton and Hove Health Screening/Medical Consent and Contact Form

STUDENT'S NAME			
STUDENT'S ADDRESS & TEL NO.			
CONTACT EMAIL ADDRESS			
STUDENT'S DATE OF BIRTH			
FAMILY DOCTOR			
EMERGENCY CONTACT NAME & NUMBER (where someone can be reached when student is in the class)			
DOES STUDENT SUFFER FROM:- (please give details if yes)	YES	NO	DETAILS
ASTHMA/RESPIRATORY CONDITION			
DIABETES			
EPILEPSY			
HEART CONDITION			
HAEMOPHILLIA/BLOOD CONDITION			
BACK/JOINT CONDITION			
DYSLEXIA			
DYSPRAXIA/CO-ORDINATION DIFFERENCES			
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)			
CONDITION RELATED TO NERVOUS SYSTEM			
AUTISM/ASPERGER'S SYNDROME			
SIGHT/HEARING DIFFERENCES			
OTHER (please give full details)			

I have completed this form to the best of my knowledge and I will inform the school should the health of the student alter at any time.

Signature:

(print name):

To be completed by parent or guardian for all under 18 students:

I am pleased to allow my son / daughter to participate in martial art classes with The Choi Foundation, Brighton and Hove. I consider my son / daughter to be physically fit and capable of full participation, but in the event that he / she should be injured when I am not present, I give my permission for the Instructor Team to obtain emergency medical treatment on his / her behalf. I understand that in event of any injury or illness all reasonable steps will be taken to contact me, and to deal with that injury / illness appropriately.

Signature:

(print name):

Dated: