|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:**  | Click or tap here to enter text. | **Date of Birth:** | Click or tap here to enter text. | **Age:** | Click or tap here to enter text. |
|  |
| **Date of stay:** | Click or tap here to enter text. | **Group/School** | Click or tap here to enter text. | **Form** | Click or tap here to enter text. |
|  |
| **Home Address:** | Click or tap here to enter text. |

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| **Emergency Contact Details 1** |
| **Name:** | Click or tap here to enter text. | **Relationship** | Click or tap here to enter text. |
|  |
| **Tel. Numbers:**  |
| **Home** | Click or tap here to enter text. | **Work** | Click or tap here to enter text. | **Mobile** | Click or tap here to enter text. |

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| **Emergency Contact Details 2** |
| **Name:** | Click or tap here to enter text. | **Relationship** | Click or tap here to enter text. |
|  |
| **Tel. Numbers:**  |
| **Home** | Click or tap here to enter text. | **Work** | Click or tap here to enter text. | **Mobile** | Click or tap here to enter text. |

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| --- | --- |
| **­­­­­­Home Doctors Name, Address & Phone Number** | Click or tap here to enter text. |
|  |
| **National Health Service Number (if known):** | Click or tap here to enter text. |

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| **Medical conditions and allergies** that we should be aware of, including any current medication.**If none please write none. If left blank we will assume none.**If more room needed please use additional information box |
| Click or tap here to enter text. |
| **Date of last anti tetanus injection** | Click or tap here to enter text. |

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| **Dietary Requirements** (e.g. religious or medical) **If none please write none. If left blank we will assume none.**If more room needed please use additional information box. |
| Click or tap here to enter text. |

**To help us enhance the experience, is there anything else we need to know about the participant?**

**If none please write none.**

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| --- |
| Click or tap here to enter text. |

* I agree to the above named attending the course provided by Bolton School Services Ltd
* I give my consent for the accompanying staff/group leaders on the trip to arrange for any necessary hospital treatment, first aid or the administration of treatment for minor ailments.
* I agree to photos of myself/my child (delete as applicable) being used for social media and marketing purposes **YES** [ ] **/ NO**[ ]  **(check as applicable)**
* A copy of this form will be stored securely for legal reasons (for 6 years after the date of your visit (adults) or 6 years after a child’s 18th Birthday) at Patterdale Hall, for further reference should the need arise.

Please notify Patterdale Hall of any changes to this Information.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** | Click or tap here to enter text. | **Date:** | Click or tap here to enter text. |
| **Print name of signatory** | Click or tap here to enter text. |
| (Parent/Guardian if under 18) |

|  |
| --- |
| **Additional Information** |
| Click or tap here to enter text. |