

MEDICAL DECLARATION FORM

THE INFORMATION PROVIDED ON THIS FORM WILL BE TREATED AS CONFIDENTIAL.

Details provided should enable those facilitating your outdoor activity experience to provide appropriate medical help and support if required.

Outdoor Activity/s being undertaken:

Date of experience:

Full Name:

Address:

Name & Address of own doctor:

Own Doctor's Telephone number:

Name & contact numbers of person to be contacted, in the event of an emergency:

Detail of any medical condition, which may affect your participation in this activity/s:

Detail of any medication you take that you consider relevant to your participation in this activity:

If NO medical conditions or medication please state 'NONE'

Signed Date

NB: If you are in any doubt about your physical ability to participate in this experience, please consult your own doctor.

Whilst every effort will be made during sessions to safeguard your well being, outdoor activities do carry an element of risk and unavoidable accidents can occur.

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