

## BROMLEY TTC MEDICAL & CONSENT FORM

### SECTION1: PLAYER INFORMATION

Player Surname: <input style="width: 95%;" type="text"/> Address Line 1: <input style="width: 95%;" type="text"/> Address Line 2: <input style="width: 95%;" type="text"/> Town: <input style="width: 95%;" type="text"/> County: <input style="width: 95%;" type="text"/> Postcode: <input style="width: 95%;" type="text"/>	Player Forename: <input style="width: 95%;" type="text"/> Tel (inc STD): <input style="width: 95%;" type="text"/> Mobile: <input style="width: 95%;" type="text"/> E-Mail: <input style="width: 95%;" type="text"/> Date of Birth: <input style="width: 95%;" type="text"/> Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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This information will be needed if selected to travel abroad.

Passport Number: <input style="width: 95%;" type="text"/>
Passport Expiry Date: <input style="width: 95%;" type="text"/>
Nationality: <input style="width: 95%;" type="text"/>

Parent / Guardian Name: <input style="width: 95%;" type="text"/> Address Line 1: <input style="width: 95%;" type="text"/> Address Line 2: <input style="width: 95%;" type="text"/> Town: <input style="width: 95%;" type="text"/> County: <input style="width: 95%;" type="text"/> Postcode: <input style="width: 95%;" type="text"/> Tel (inc STD): <input style="width: 95%;" type="text"/> Mobile: <input style="width: 95%;" type="text"/> E-mail: <input style="width: 95%;" type="text"/> Relationship to Player: <input style="width: 95%;" type="text"/>
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Emergency Contact: <input style="width: 95%;" type="text"/> Address Line 1: <input style="width: 95%;" type="text"/> Address Line 2: <input style="width: 95%;" type="text"/> Town: <input style="width: 95%;" type="text"/> County: <input style="width: 95%;" type="text"/> Postcode: <input style="width: 95%;" type="text"/> Tel (inc STD): <input style="width: 95%;" type="text"/> Mobile: <input style="width: 95%;" type="text"/> E-Mail: <input style="width: 95%;" type="text"/> Relationship to Player: <input style="width: 95%;" type="text"/>
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### SECTION 2: MEDICAL HISTORY & INFORMATION

Doctors Name: <input style="width: 95%;" type="text"/>
Surgery Name: <input style="width: 95%;" type="text"/>
Tel (inc STD): <input style="width: 95%;" type="text"/>

Address Line 1: <input style="width: 95%;" type="text"/>
Address Line 2: <input style="width: 95%;" type="text"/>
Town: <input style="width: 95%;" type="text"/>
County: <input style="width: 95%;" type="text"/>
Postcode: <input style="width: 95%;" type="text"/>

PAST /CURRENT MEDICAL HISTORY (please detail operations/hospital admissions & major illnesses - with dates)

PAST / CURRENT INJURY HISTORY (please detail injuries necessitating 2 or more months out of sport - with dates)

HISTORY OF ASTHMA/ECZEMA

ALLERGIES  
(e.g. Hay Fever / Elastoplasts / Bee Stings etc)

**CURRENT / REGULAR MEDICATIONS**

(including vitamins and nutritional supplements)

**ALLERGIES TO MEDICATIONS**

(if any)

**VACCINATIONS RECEIVED**

Has your child received any of the following vaccinations?

Polio:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	
Typhoid:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	
Hepatitis A:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	
Hepatitis B:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	
Tetanus:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	
T.B:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	
MMR:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	
Meningitis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	

**TREATMENT PERMISSION**

If necessary, can your child be given the following treatment?

Physiotherapy:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sports Massage:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Paracetamol:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ibuprofen:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Local Anti-Inflammatory:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Savlon Antiseptic Spray:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough Syrup/Pastilles:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immodium (for diarrhoea):	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**DIETRY REQUIREMENTS**

(please provide details of such requirements)

If a current Therapeutic Use Exemption Form is held (TUE/aTUE), please provide brief details here

**ANY OTHER MATTERS TO BE AWARE OF (such as social relationships)****SECTION 3: DECLARATIONS (please read the below carefully)**

Please be aware there may be still or video cameras used at training sessions/camps, and competitions which may be used for the purposes of coaching analysis, resource production and the ETTA website only. All footage will be deleted or stored securely. Do you approve of your child being photographed or videoed?

 No  Yes

Do you consent that your child may travel to, from and during tournaments with ETTA/BTTF approved coaches? (Coaches driving hired vehicles will be over the age of 25 holding a current driving license. All vehicles will be fully roadworthy)

 No  Yes

Has your child read and understood/been made fully aware of and understood the ETTA / BTTF Players Code of Conduct?

 No  Yes

Do you consent to your child receiving First Aid or treatment (including administration of anaesthetic or surgical operation) deemed necessary by a qualified medical practitioner should an emergency occur when your consent to the particular treatment cannot otherwise be reasonably obtained?

 No  Yes

I declare that the information provided within this form is true and correct. I confirm that I understand it to be my responsibility to inform the ETTA/BTTF of any updates to this form. I agree that any medical information may be discussed between the medical and performance coaching staff, where such information may have an impact on my / my child's ability to train or compete.

Parent / Guardian  
Signature:

Date:

Players Signature:

Date: