



MEDICAL FORM

Course Details

Course Name _____

Date of Course _____

Personal Details

Title (Mr / Mrs) _____ Full Name _____

Address _____

_____ Post Code _____

Phone _____ Mobile _____

E-mail _____

Age _____

Medical Conditions, Allergies or Disabilities

Dietary Requirements **Vegetarian** **Vegan** **Other** (Please specify) _____
(Please delete circle as appropriate)

Next of Kin

Title (Mr/Mrs) _____ Full Name _____

Address _____

_____ Post Code _____

Phone _____ Mobile _____

Relationship _____

Declaration

I confirm that I have read, understood, and agree to abide by the **Terms and Conditions** and that I have filled out the **Medical Conditions, Allergies or Disabilities** section on this form.

If under the age of 18 this section must be signed by a parent or legal guardian.

Signed _____

Print Name _____

Date _____