PARENTAL TRAVEL MEDICAL INFORMATION

I agree to my child …….. receiving medication as instructed and any emergency dental, medical or surgical treatment, including anesthetic or blood transfusion, as considered necessary by the medical authorities present. I understand the extent and limitation of the insurance cover provided.

Parent/Guardian's Name……..……..

Home Address ……..……..……..……..……..
……..……..……..……
Telephone: (H) …..... (W) ……..…….... (M)……
.
Alternative Emergency contact details:
Name ……..……..……
Address …...……..……
……..……...
Telephone: (H) …..... (W) ……..…….... (M) ……..……

Relationship to child ……..……..…….
Name of Child's Doctor ……..……..
Address of Doctor ……..…….. ……
……..……
Telephone Number of Doctor ……..……

Signed…….**Date**…….....

Name (capitals)……..……..……..……..

Please Return this form to the St Pauls FC Coach / Co-ordinator

St Paul's Football Club,
Le Clos des Pauvres, La Rue De Chateau Clairval,
St Saviour, Jersey, Channel Islands