Weardale Adventure Centre

Ireshopeburn, County Durham, DL13 1HB
Tel: 01388 537387
Web: www.weardaleadventurecentre.co.uk

Personal Information & Consent Form (Please complete fully)

Participants Details

First Names: …… Surname: …….

Date of Birth: ……..... Gender: Male / Female / Other

Tel: …….. Email: …….. Address:

……..

Please also provide your Doctor's Name, Address and Phone Number:

……
……

Emergency Contact Details

Name: ……. Relationship: …….

Tel: (Mob) …….. (Home) …….. (Work) ……..

Consent

I consent to any emergency medical treatment, including anaesthetic, which may be necessary as part of a medical emergency during time at the Centre. I accept that whilst the Centre and its employees will take all reasonable care to ensure my safety and wellbeing, with all adventure activities there is still an element of risk and injury. Weardale Adventure Centre cannot be held responsible for loss, damage or injury suffered as a result of activities.

Photographic Consent

Members of the Centre staff may take photographs of you taking part in activities (please note that photographs would never be taken within the residential areas of the Centre, other than the dining hall or meeting rooms). The photographs will only be used for our future publicity including on our website and social media pages. They will never be given to any third party. Do you consent to photographs being taken: Yes ☐ No ☐

I confirm that within the last 14 days:

I have not been infected or shown symptoms of Covid-19

No one in my household has been infected or shown symptoms of Covid-19

No one in my household is in the vulnerable or extremely vulnerable categories as defined in the current UK Government advice.

Please tick to confirm the above: ☐

Medical Information

(Please circle yes or no for every question.)

It is very important that this information if complete and accurate. If you answer 'yes' to any question, please give details in the box provided.

Do you have:		Details
Heart trouble, angina, raised blood pressure?	Yes/No	
Asthma, bronchitis, tuberculosis, or any other lung condition?	Yes/No	
Diabetes?	Yes/No	
Epilepsy, fainting attacks, migraine, severe head injury?	Yes/No	
Allergy to foods (e.g. nuts, dairy etc.?) ***Or any other dietary requirement?***	Yes/No	
Other allergic reactions (e.g. beestings, mosquito bites etc.?)	Yes/No	
Nervous illness, depression or any psychiatric condition?	Yes/No	
History of broken bones, muscle tears, or tendon/ligament damage?	Yes/No	
Stomach, digestive, abdominal problems?	Yes/No	
Bladder, urinary problems?	Yes/No	
Severe hearing or visual impairments?	Yes/No	
Have you been treated by a doctor in the last two years for anything other than a trivial complaint?	Yes/No	
Are you taking any medication? If so, please state the condition being treated, name the medication and state the dosage.	Yes/No	
If female, do you know or suspect that you are pregnant? If yes, please give details.	Yes/No	
Is there anything else you would like to disclose?	Yes/No	

I confirm that all information including the medical questionnaire are complete and accurate.

Participant / Parent / Guardian Name: ……. Date: ……..
Signature: ……..