



**HOCKEY CAMP 2011**  
**MONDAY 15<sup>TH</sup> – FRIDAY 19<sup>TH</sup> AUGUST**

**MEDICAL FORM**

CHILD'S NAME:

[BLOCK CAPS]

DATE OF BIRTH:

ALLERGIES/ANY MEDICAL CONDITION:

NAME OF DOCTOR:

DOCTOR'S TELEPHONE NUMBER:

ADDRESS OF SURGERY:

*I [parent/guardian] give permission to Ben Lamb, Head Coach/First Aider or his representative to give consent for any emergency medical treatment to my child [child's name]*

.....

*deemed necessary by a doctor following an accident or other emergency.*

SIGNED [PARENT/GUARDIAN]:

DATE:

*Please return to: Ben Lamb: 63 Lincoln Way, North Wingfield, Chesterfield, Derbyshire S42 5RR.*