

CHOYSEZ

Gooch Avenue ~ Barrington Industrial Estate ~ Bedlington ~ NE22 7DQ
 Tel: 01670 821515 Fax: 01670 825149 Email: admin@choysez.org

CONFIDENTIAL
PERSONAL INFORMATION

Please complete this form in PEN and in BLOCK CAPITALS and return it to CHOYSEZ as soon as possible.

<p><u>YOUR DETAILS</u></p> <p>FIRST NAME(S)</p> <p>SURNAME.....</p> <p>ADDRESS.....POSTCODE.....</p> <p>DATE OF BIRTH.....MALE/FEMALE.....</p> <p>TELEPHONE(day).....</p> <p style="padding-left: 40px;">(evening).....</p> <p>ETHNIC ORIGIN (please tick)</p> <p> <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Mixed <input type="checkbox"/> White <input type="checkbox"/> Any Other <input type="checkbox"/> Do not wish to state </p> <p><u>NATIONALITY</u>.....</p>	<p>Photograph of Young Person</p> <div style="border: 1px solid black; width: 100%; height: 150px; margin: 10px 0;"></div> <p>To be taken at Choysez on Initial Contact Meeting</p>
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<p><u>Medical Information</u></p> <p>In your child's interest, it is important that Choysez know whether he or she has any illness or medical condition.</p> <p>Does your child suffer from any conditions that Choysez should be aware of? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If YES please provide details e.g Illness, Travel Sickness, allergies etc.....</p> <p>.....</p> <p>Details of any medication:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 25%;">Name of medication</th> <th style="width: 25%;">Dosage</th> <th style="width: 25%;">Times of day or circumstances to be given</th> <th style="width: 25%;">Method of administration</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Name of medication	Dosage	Times of day or circumstances to be given	Method of administration				
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I give my consent**for a member of staff to administer the above medication which I will deliver to Choysez. I understand that the staff at Choysez are not qualified practitioners but they will take reasonable care in the administration of the medication and will endeavour to respond appropriately should emergency treatment be required.

I give my consent** for my son/daughter to self administer the above medication.

** Delete as applicable.

- To the best of your knowledge has your son/daughter been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be, or become contagious or infection?

Yes No

If **YES** please detail
.....

- Is your son/daughter allergic to any medication?

Yes No

If **YES** please detail
.....

- When did your son daughter last receive a tetnus injection? ____/____/____

- Please outline any dietary requirements of your child:.....

I undertake to inform Choysez as soon as possible of any changes in the medical information provided on this form.

WHO SHOULD WE CONTACT IN AN EMERGENCY

RELATIONSHIP TO YOU (parent/guardian/relative).....

FIRST NAME..... **SURNAME**.....

ADDRESS.....

..... **POSTCODE**.....

TELEPHONE(home)..... **(work)**.....

ADDITIONAL INFORMATION.....

DOCTOR DETAILS

Name..... **Surgery**.....

Address.....

Telephone.....

To be completed by Parent/Guardian if participant is under 18 years of age.

Throughout the course there will be a variety of activities. For each activity a consent form will be required, which will be given out prior to the activity. In the event of a signed consent form not being brought to Choysez on the day of the activity you the (parent/guardian) will be informed along with the referral agent and it will be up to you to make alternative arrangements for the young person.

I the parent/guardian of consent to him/her receiving medical, dental or surgical treatment (including the administration of anaesthetics) that may be advised by a Doctor should I not be able to be contacted, following attempts to do so, prior to such treatment being administered.

Signedparent/guardian Name (print)
Date

BOTH SECTIONS TO BE COMPLETED BY THE CLIENT

Please sign that you (the client) are willing for this information to be entered on Choysez's database in accordance with the Company's registration under the Data Protection Act 1984.

Signed..... Name
(print).....Date.....

Please sign below if you (the client) consent to the use any photographs of yourself in Choysez from time to time on displays.

Signed.....Name(print).....
Date

TO BE COMPLETED BY PARENT OR GUARDIAN

If the client is under 18 Parent or Guardian also to sign to give permission for photographs of client to be used in Choysez marketing and publicity information.

Please sign that you (parent/guardian) are willing for photographs of client to be used as above.

Signed.....Name (print).....
Date