**WEST RIDING COUNTY FA**

**PARTICIPANT CONSENT FORM**

***Confidentiality:***

*Details on this form will be held securely and will only be shared with event organisers and appointed staff*

*or others who need this information in order to meet the specific needs of your child.*

|  |  |
| --- | --- |
| Activity Name  |  |

**SECTION 1: The Child (the participant)**

|  |  |
| --- | --- |
| Name of child/young person: |  |
| Address |  |
|  | Post code |  |
| Contact Tel (Home) |  |
| Gender (please circle)  | Male / Female | Date of Birth (dd/mm/yyyy) |  |
| Does the child have a Disability? (please circle)  | YES / NO |
| If yes, please specify  |  |
| Does the participant require any reasonable adjustments?  | *This could include physical adjustments to the playing/meeting space, additional support on the day of the event, pre- event support.*  |
| Do you require a member of the West Riding FA team to contact you prior to the event to discuss your requirements? (please circle) | YES / NO |

**SECTION 2: Parent/ Carer Details**

|  |  |
| --- | --- |
| Name of parent/ carer: |  |
| Address (if different from above)  |  |
|  | Post code |  |
| Contact Tel (Home) |  | Contact Tel (Mobile)  |  |
| Email Address  |  |

**SECTION 3: Emergency Contact Details**

|  |  |
| --- | --- |
| Name of person to contact in an emergency  |  |
| Relationship to the child  |  |
|  | Post code |  |
| Contact Tel (Home) |  | Contact Tel (Mobile)  |  |
| Email Address  |  |

**SECTION 4: Medical Information**

|  |  |
| --- | --- |
| Any medical conditions that we should be aware of? (please circle) | YES / NO |
| If yes, please specify  |  |
| Does the condition require medication?  | YES / NO |
| If yes, please provide the following details:  |
| Name of the Medication  |  |
| How is the medication administered?  |  |
| How often is the medication administrated? |  |
| Does the participant have any allergies?  | YES / NO |
| If yes, please specify  |  |
| Does the participant have any dietary requirements (vegan/vegetarian): | YES / NO |
| If yes, please specify  |  |

**SECTION 5: CONSENT -** *please tick the boxes below*

|  |  |
| --- | --- |
| **Consent**  | **(✓)** |
| I give my consent that if an emergency medical situation arises, West Riding FA may act as loco parentis. If the need arises for administration of first aid and/or other medical treatment which in the opinion of a qualified medical practitioner may be necessary. I also understand that in such circumstances that all reasonable steps are made. |  |
| I give my consent for my child to be photographed (photo and video) for marketing and communication purposes. The footage will only be used by West Riding FA and will not be passed on.  |  |
|  |  |
| **I confirm that I have read, or been made aware of, the organisation’s policies concerning:** | **(✓)** |
| Codes for conduct for parents, coaches, children & young people |  |
| Changing room policy |  |
| Transport policy |  |
| Safeguarding rules and expectations  |  |
| Photography, videoing, texting and use of social media policies |  |
| Whistleblowing Policy  |  |
|  |  |
| **I can confirm that my child is aware of (if aged 11 yrs +)** | **(✓)** |
| West Riding County FA Code of Conduct for Children  |  |
| West Riding County FA Anti-Bullying Policy |  |
| Whistleblowing Policy  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Print name child/young person: (if aged 16 – 18yrs) |  | **Date** |  |
| Signature of child/young person:(if aged 16 – 18yrs) |  |
| Print name parent/carer: |  | **Date** |  |
| Signature parent/carer: |  |