

PARTICIPANT'S NAME:	PARTICIPANT'S DATE OF BIRTH

CONTACT DETAILS: Please provide full postal address and telephone numbers:	HOME	
	WORK	
	MOBILE	
	OTHER	
	EMAIL	Please only provide if you wish to receive information via Email:

ACTIVITY CHOSEN:		DATE:	
ACTIVITY FEES & PAYMENT METHOD:			

PARTICIPANT'S DETAILS: Please provide details of any medical conditions / allergies or different requirements, which we can use to further enhance the participant's water sports experience.

MEDICAL CONSENT: I, the signatory below, agree to authorised members of staff giving consent on my behalf for an anaesthetic to be administered or for any other urgent medical treatment to be given to the participant on the advice of a qualified medical practitioner. Medical consent can only be given by the participant (over 18 years) or their parent / guardian (under 18 years).

SIGNATURE OF MEDICAL CONSENT	SIGNATORY DETAILS (IF NOT PARTICIPANT) – Please print NAME: ADDRESS:
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IMMEDIATE & EMERGENCY CONTACTS

MEDICAL / URGENT TREATMENT Please provide clear details of whom the Centre should contact in the event that medical / urgent treatment is required:	INCLEMENT WEATHER Please provide clear details of whom the Centre would contact (if not the participant) or who has parental responsibility to collect the participant should it be necessary to close the Centre due to inclement weather conditions:
NAME:	NAME:
ADDRESS:	ADDRESS:
IMMEDIATE CONTACT NO:	IMMEDIATE CONTACT NO:

To assist us with our marketing strategy please indicate where you saw this activity advertised i.e. Website/Brochure/Flyer etc

PHOTOGRAPHY DISCLAIMER (UNDER 18)
 I am happy for photographs of my son/daughter/ward to be used in Dover Water Sports Centre publicity or publications
 YES / NO*
**Delete as applicable*