F.A.R.S. Partnership Code Form

Name Function within the team:

Address

Postcode

Telephone number

Next of Kin Contact Address (if different from above) N.B. if necessary please give any alternative contact address and telephone nos.

Postcode

Contact Telephone Numbers (if different to above)

I undertake to pay the required sums by the dates specified in the information and accept that in respect of any withdrawal from the trip, for whatever reason, there can be no refund of the whole or part of the payments unless the circumstances are covered by insurance.

Medical Information

Any specific medical conditions requiring medical treatment and/or medication?

☐ Yes If yes give details

☐ No

Any Allergies?

☐ Yes If yes give details

☐ No

Any contact with contagious or infectious diseases within the last four weeks?

☐ Yes If yes give details

☐ No

Please detail any specific dietary requirements and the type of pain/flu relief medication that may be given if necessary

I have read the F.A.R.S. **Partnership Code** and agree that I will abide by this and I understand that a serious or continued breach of this code may result in me being dismissed from my duty to the team and may exclude my participation in future team/visits.

Signed……Date…… (Coaches/trainers/staff must be over 18 years)

I confirm that I have received the details of the above activity (including Travel Arrangements) and consent to my being included in the visits and activities indicated

I have read the skater's code of conduct and agree to assist in the upholding of the contents. I also have read and understand the FARS child protection policies. I understand that serious or continued breach of these codes or policy may result in my being excluded on future team activities and visits.

I, ……. Being the above named person hereby give permission for the group leader to give the necessary authority on my behalf for any medical or surgical treatment recommended by competent medical authorities, where it would be contrary to my health. In the doctor's medical opinion, for any delay to be incurred by seeking my personal or family consent.

Signature…… Print Name…… Date……

Event:…… Country:…… Duration of trip:……