

THE GHANA BADMINTON ASSOCIATION OF GHANA LIMITED



PARENTAL CONSENT FORM

[Travel away from Home]

CONFIDENTIAL

TRAVELING ATHLETE

FULL NAME OF ATHLETE:

DOB:

HOME ADDRESS:

CLUB:

REGISTERED No:

PARENT / GUARDIAN

FULL NAME OF PARENT / GUARDIAN:

RELATIONSHIP:

HOME ADDRESS:

ALL 24 Hr. CONTACT NUMBERS: [HOME]: [WORK]: [MB]:

DETAILS OF ALTERNATIVE EMERGENCY CONTACT

FULL NAME:

RELATIONSHIP:

CONTACT ADDRESS:

ALL 24 Hr CONTACT NUMBERS:

DETAILS OF FAMILY DOCTOR

PRACTICE NAME AND ADDRESS:

NAME OF FAMILY GP:

TEL NUMBER OF SURGERY:

DETAILS OF EVENT

NAME OF EVENT:

FULL ADDRESS OF EVENT:

DURATION OF EVENT:

ACTIVITY WITHIN EVENT THAT ATHLETE WILL BE ENGAGED IN:
[Include alternatives if planned ie: Swimming, football etc]

TRANSPORT

MODE OF TRANSPORT:

LOCATION OF PICK-UP:

TIME OF PICK-UP:

LOCATION OF DROP-OFF:

TIME OF RETURN:

SENIOR SUPERVISING MEMBER OF PARTY

NAME:

POSITION:

24 Hr. CONTACT NUMBERS:

CHILD PROTECTION LEAD OF PARTY IF DIFFERENT TO ABOVE

NAME:

24 Hr CONTACT NUMBERS:

ACCOMODATION

FULL ADDRESS OF ACCOMODATION:

TELEPHONE NUMBER OF HOTEL / HOST FAMILY ETC:

ANTICIPATED TIME OF ARRIVAL:

DEPARTURE DATE: DEPARTURE TIME:

TYPE OF ACCOMODATION: [Dormitory] [Twin Room] [Single Room] [Host Family] Other:

DETAILS OF INSURANCES IN FORCE FOR THIS TRIP:

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DECLARATION

DECLARATION BY PARENT / GUARDIAN

I agree / do not agree to [Name]:participating in the activities shown.

- Please outline any medication which the athlete is required to take including frequency

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- Indicate if you wish a supervising adult to administer this medication YES / NO

- Indicate any dietary requirements of the athlete

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- Indicate any cultural requirements the athlete may have:

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- Does the athlete have any allergies YES / NO

If YES please describe:

- Does the athlete have any contagious diseases YES / NO

If YES please describe:

- When did the athlete last have a Tetanus Injection DATE:

Please inform the club / Division / Association if this medical information changes in any way prior to the trip

- *Are there any issues or concerns [which will be dealt with in the strictest confidence] that you feel the supervising adult should be aware of*

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I have been made aware of / provided with a Copy of The Ghana Badminton Association 'Child Protection Policy'.

I fully understand the extent and limitations of the insurance cover provided by the Club / Division / Association.

I agree to my son / daughter receiving medication as instructed and any emergency dental treatment, medical or surgical treatment including anesthetic or blood transfusion as considered necessary by the competent medical authorities present.

FULL NAME OF PARENT OR GUARDIAN: **RELATIONSHIP:**
USE BLOCK CAPITALS PLEASE

SIGNATURE:

DATE: