

Referral No: _____

Carmarthenshire Disabled Sports and Activities Club

Doctors Consent Form

The Carmarthenshire Disabled Sports and Activities club is open for individuals with a Physical and/or Sensory disability that would like to participate in a variety of activities and sports. During each activity, Support Workers are in attendance to assist and help the clients with any specific care needs.

To ensure that the clients are able to participate in their chosen activities, it would be greatly appreciated if the form below be completed and passed back to the client.

Name of Client: _____	DOB: _____
Address: _____	Telephone No: _____
_____	Practice Stamp
Post code: _____	<input type="text"/>

Doctors Name: _____	Medical Practice: _____
Date : _____	

Activities available to Clients: Please indicate which activities the client is physically able to take part in. Please tick all that apply

Indoor Bowls	<input type="checkbox"/>		
Archery	<input type="checkbox"/>	Boccia (similar to French Boules – participants play whilst seated)	<input type="checkbox"/>
Short Mat Bowls	<input type="checkbox"/>	Indoor Climbing	<input type="checkbox"/>
Gym based activity – weights	<input type="checkbox"/>	Orienteering	<input type="checkbox"/>
Gym based activity – cardiovascular	<input type="checkbox"/>	Sailing	<input type="checkbox"/>
Canoeing (in a swimming pool)	<input type="checkbox"/>	New Age Kurling (Similar to Curling but played in a Sports Hall)	<input type="checkbox"/>
Coasteering	<input type="checkbox"/>	Open Boating	<input type="checkbox"/>
Abseiling	<input type="checkbox"/>	Art and Crafts	<input type="checkbox"/>

Please attach medication printout _____

This Client is able to participate in the above activities within the Carmarthenshire Disabled Sports and Activities club.

Signature of Referrer (GP): _____ Date: _____

I hereby give consent to the above GP and medical practice to forward details of my medical records to the staff of the Carmarthenshire Disabled Sports and Activities Club so that I can take part in appropriate activities, safe for my ability, and medical conditions..

I understand that only information relevant to the activities will be forwarded. This information will only be referred to in case of a medical emergency.

Participant Signature: _____ **Date:** _____

Name (in capitals): _____