Registration & General Consent Form (Adult)

Full Name ____________________

Likes to be called ____________________

Date of birth ____________________ Age ____________________

Address ____________________

____________________ Postcode ____________________

Mobile telephone number ____________________

Other telephone nos. ____________________

Email address ____________________

Next of Kin

Name ____________________

Address *(if different to above)* ____________________

____________________ Postcode ____________________

Contact number(s) ____________________

Email address ____________________

Emergency contact details (this should be the person who would be able to respond in the case of an emergency).

1st Contact

Name ____

Contact number(s) ____

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Address *(if different to previous)* ____

______________________________ Postcode ___________________________

Relationship to person ____

2nd Contact

Name ____

Contact number(s) ____

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Address ____

______________________________ Postcode ___________________________

Relationship to person ____

Medical details

Is tetanus injection up to date? Yes/No

Any known medical conditions or disability? Please give full details _______________

Describe mobility and list any mobility equipment used and frequency

eg wheelchair user just for long distances, powered wheelchair used all the time, walk unaided etc

Food allergies or special requirements

Will any medication be needed whilst at event? Yes/No

Can you self-administer medication? Yes/No

If assistance is needed with medication please contact us on 07900 278780.

Doctor information

Name of family doctor ____

Telephone number ____

Address ____

__________________________ Postcode ________________________

More detail

Personal care requirements – please give us as much detail as possible regarding any support you wish us to provide ie help whilst using a bathroom, dressing, eating, drinking, means of transferring, support handling money and any other specific directions you wish to give. If you are independent, please also tell us. Please feel free to continue on a separate page.

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Further Information – please use this space to inform us of anything else you would like us to know; likes and dislikes, anything which we can try to do to help you participate at our events (eg. provision of a shower chair or a changing bed etc)

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Communication - this may include: sign interpretation, makaton, communication boards, assistive technologies, symbols, induction loops, braille, simple language etc. Preferred communication method, other methods, Communication equipment required, any other considerations:

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Data protection

The Mae Murray Foundation values personal privacy and all information collected will be stored in line with our Data Protection Policy and Procedures. A copy is available upon request. This information will always be kept safe and secure. We will not share your information with any third party. You can view our full Privacy Policy by visiting our website: www.maemurrayfoundation.org .

We would like to correspond with you about membership benefits, events, projects design, and how we can improve the service we provide to you and/or your family. We may also send information from other organisations that may be of benefit to you and your family. We will correspond with you in a variety of ways such as: by post, telephone, email and SMS. If you agree to your information, which is essential for safe-guarding to be stored in line with data protection procedures and to being contacted this way, please sign below:

Signature:

………………………………………………………………………

Print name: ………………………………………………….**Date:** ………………………………

Participant Authorisation

I (name) ………………………………………… wish to take part in activities of the Mae Murray Foundation and undertake to ensure that any equipment which I bring along, for my own personal use, will be kept in good working condition.

In an emergency I consent to receiving essential hospital or dental treatment including anaesthetic as deemed necessary by medical professionals.

Signature ……….. ………………………………………………………………

Print name: **Date:**

…………………………………………………………………………………………………..

Please note: The form is now completed unless you are a vulnerable adult or adult in need of any assistance with decision making regarding personal safety. If this applies to you then you must ask your legal guardian to also complete the following pages and associated consent.

** **This portion of the form only needs to be completed by a guardian for adults who may be at risk of harm or in need of protection** ie those who need assistance with decision making to stay safe **

Choices/Decisions – Tell us about the support required to help with choices and decision making and anything else you feel it is important we know and relevant to safe and enjoyable participation at Mae Murray Foundation events ? *eg.choosing own food, staying safe generally, dislike of loud noises, danger awareness. Please continue on a separate page if necessary*

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Guardian Authorisation – only if applicable

I give permission for ………………………………………… to take part in the normal activities of this group. I understand that separate permission will be sought for certain activities, including outings lasting longer than the normal meetings times of the group.

In an emergency and/or I cannot be contacted, I consent to essential hospital or dental treatment including anaesthetic being given, as deemed necessary by medical professionals.

Signature of guardian (with legal responsibility):

…………………………………………………………………………

Print name: Date:

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Data protection

The Mae Murray Foundation values personal privacy and all information collected will be stored in line with our Data Protection Policy and Procedures. A copy is available upon request. Participants can request to view information we hold about them at any time. This information will always be kept safe and secure.

Please delete as appropriate:

- I give my permission for this information, which is essential for Safe-guarding to be stored in line with Data Protection procedures.

Signature of guardian (with legal responsibility):

…………………………………………………………………………

Print name: Date:

……………………………………………………………………………………………………

Medical/Nursing Assistance or Intervention

Mae Murray Foundation
Creating Change Together

If assistance with administration of medication is needed, or if our staff will be required to assist with any specific medical or nursing need - which may require specific training, then please ask your GP to complete the details below and submit it to us as soon as possible. We will need to assess this need to ensure we have staff with appropriate training before confirming participation. Thank you.

Medication	Dosage	Frequency

Please state any medical/nursing need eg.colostomy etc or any assistance which may need to be given to the below named patient which requires specific medical training; eg epileptic seizures etc

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I ………………………………………………….. (GP Name Block Capitals) confirm that the above information hereby given in respect of the below named patient is correct as of (date) ……………………………

(Name of patient)………………………………… D.O.B. ………………………………………

GP Signature ………………………………………………………………………………………………

I ……………………………….. (Participant Name) being the above named person hereby agree to immediately inform the Mae Murray Foundation of any changes to this information.

SIGNED …………………………………………… Date …………………………………………

OR / If appropriate

I ……………………………….. (Guardian Name) being the legal guardian of the above named person hereby agree to immediately inform the Mae Murray Foundation of any changes to this information.

SIGNED …………………………………………… Date …………………………………………