Larkhall YMCA Harriers

Membership Form

Name:

Address:

Telephone: **Date of Birth:**

In the event of an emergency contact:

Name:

Address:

Telephone:

Name and Address of Doctor:

Telephone Number:

Medical History

Please inform us below of any medication you/your son/daughter is allergic to, together with details of any long term medication taken at present:

Allergies:

Medication:

Should any of the above information change, please advise the club as soon as possible.

I confirm that it IS / IS NOT in order to authorise any medical treatment to me / my son / daughter in the event of an emergency.

Please note that the above information will be kept in the strictest confidence.

Signed: **Member / Parent / Legal Guardian**

Date: