

5<sup>th</sup> May 2015 01639 861111 v.radmore@neath-porttalbot.gov.uk

Victoria Radmore

Dear Parent

During the summer I have organised a Festival of Sport for children aged 7 - 18yrs, with learning, physical, visual and hearing impairments.

#### (Priority to children with physical and visual impairment)

The purpose of the week is to provide opportunities for your child / children to feed into mainstream clubs.

This is **NOT** a respite service and we will only be excepting children who want to participate in a club based activity after the event.

The week's activities will include football, rugby, archery, canoeing, shooting and lots more.

The event will be held at:

Venue:Margam Country ParkDate: $24^{th} - 28^{th}$  AugustTime:9.30 - 3.00

Yours sincerely

Victoria Radmore Disability Sport Wales Development Officer

Please return to:

Library Head Quarters Reginald Street Velindre Port Talbot SA13 1YY Fax: 01639 861119

# FESTIVAL OF SPORT $24^{th} - 28^{th}$ August 2015

Child/Children's Name:					
Address:					
Date of Birth:	Age:				
Disability:					
Contact number:	Mobile:				
Alternative names and telephone No's to be contacted in an emergency					
Name	Relationship to child				
Address					
Contact Number					
Transport Required	YES / NO				

### **Medical / Photographic Information**

Name of G.P....

Telephone number of G.P....

Address.....

I authorise consent to any medical treatment deemed necessary to my child/children, should an accident occur and I cannot be contacted.

I authorise consent to Neath Port-Talbot Council for photographs/ video to be taken of my child/children for publicity through Physical Activity and Sport Service, Disability Sport Wales, Admiral Insurance and the Media.

Signed: ...... Parent / Guardian

#### **Medical Information**

Does your child have any conditions requiring medical treatment?	YES/NO
If YES, please give brief details:	
Does your child have any allergies?	YES/NO
If YES, please give brief details:	

Any other information about the child that may be helpful

## ONLY COMPLETE IF YOU WANT THE DISABILITY SPORT TEAM TO GIVE MEDICATION TO YOUR CHILD

Name(s) and prescribed dosage of medicine:

.....

Date and time of last dosage given: .....

Storage details:

Is the medication in the original container and prescribed to the above child? Yes/ No

Expiry date of medication?

I give my permission for the above medication to be given to my child in accordance with the details provided on this form.

Signed: ..... Parent / Guardian

FOR DISABILITY SPORT USE ONLY – MEDICINE ADMINISTERED							
DATE	TIME	DETAILS	MEDICATION	SIGNATURE	PARENT		
		CHECKED			SIGNATURE		
		YES/ NO					