

MEDICAL INFORMATION/PHOTO CONSENT



THIS FORM CAN BE USED FOR UP TO 2 LITTLE ATHLETES. PLEASE COMPLETE AND SUBMIT WHEN YOU COLLECT YOUR REGISTRATION PACK.

Family Name: _____

Email Address: _____ @ _____

First Athlete	Second Athlete
Given Name:	Given Name:
Permission given to ND Lac to seek emergency medical attention if required? YES/NO	Permission given to ND Lac to seek emergency medical attention if required? YES/NO
Any known allergies, medical problems or long term medications? YES/NO	Any known allergies, medical problems or long term medications? YES/NO
If YES, please provide details:	If YES, please provide details:
Any known disabilities: YES/NO	Any known disabilities: YES/NO

I understand and agree that Northern Districts Little Athletics Centre may collect images and footage of participants at competition, training and presentation days and may from time to time use this material for publicity purposes in print or online media, including the ND Lac website or in other ways to advertise the Centre.

Signature of parent/guardian _____

Date: _____