ROKT 14 **RECOGNITION OF RISK FORM** ROKT 14

FOR OVER 18'S

PARTICIPATION STATEMENT FROM ROCK CLIMBING UK GOVERNING BODY

"The British Mountaineering Council recognises that climbing, hill walking and mountaineering are activities with a danger of personal injury or death. Participants in these activities should be aware of and accept these risks and be responsible for their own actions and involvement".

I the undersigned accept and recognise that there are inherent risks with taking part in adventure at the venues stated below and similar venues I may visit. The specific risks are: roped rock climbing; traversing; bouldering; belaying; high and low ropes; slacklining; tyrolean traverse; abseiling; archery; indoor caving; indoor dry-tooling and other associated activities including moving belay weight bags.

DATE OF COURSE: _____/_____/_____

VENUE: ☐ ROKT ☐ OTHER (PLEASE SPECIFY) _____

PARTICIPANT DETAILS:

FULL NAME: _____ **CONTACT NUMBER:** _____

DATE OF BIRTH: ____/_____/_____ **EMAIL:** _____

ADDRESS: _____

_____ **POSTCODE**: _____

☐ TICK THIS BOX IF YOU **DO NOT** WISH TO RECEIVE ROKT INFORMATION BY EMAIL

☐ TICK THIS BOX IF YOU **DO NOT** WISH TO RECEIVE ROKT INFORMATION BY SMS

NAME OF GP (IF AVAILABLE): _____ **PHONE NUMBER**: _____

DETAILS OF ANY SPECIAL MEDICAL CONDITIONS OR ALLERGIES, FOOD INTOLERANCES OR SPECIAL DIETARY NEEDS/PREFERENCES (E.G. LACTOSE INTOLERANCE, VEGETARIAN ETC), INCLUDING CURRENT MEDICATION (AND ITS LOCATION)

_____

_____

EMERGENCY CONTACT DETAILS:

FULL NAME: _____ **CONTACT NUMBER:** _____

RELATIONSHIP TO PARTICIPANT: _____

ADDRESS (IF DIFFERENT TO ABOVE): _____

_____ **POSTCODE**: _____

FURTHER CONTACT DETAILS FOR PERSONS IN CASE WE CANNOT CONTACT ABOVE CONTACT:

NAME: _____ RELATIONSHIP: _____ CONTACT NUMBER: _____

I HAVE READ THE ABOVE PARTICIPANT STATEMENT, THE CONDITIONS OF USE AND BEST PRACTICE NOTICES. I RECOGNISE THE INHERENT RISKS INVOLVED (THIS INCLUDES INJURIES SUSTAINED DUE TO ANY FALL OR IMPACT). I UNDERSTAND THAT WHEN PARTICIPATING IN THE APPLICABLE SPORTS ANY INSTRUCTIONS GIVEN BY STAFF MUST BE ADHERED TO. I AGREE TO INFORM STAFF OF ANY CHANGES IN MY HEALTH, NEEDS AND ANY MEDICAL TREATMENT RECEIVED.

SIGNED: _____ **DATE:** _____/_____/_____

THIS PART TO BE FILLED IN BY RECEPTION STAFF

FORM CHECKED BY: SIGNED: DATE: