



Information: general health

PLEASE RETURN THIS FORM, COMPLETED AND SIGNED, TO THE
GUIDER-IN-CHARGE ON _____ (DATE)

COMPLETE IN BALL-POINT PEN IN BLOCK CAPITALS. DELETE STARRED *ITEMS AS APPROPRIATE

NOTE: THIS INFORMATION WILL BE HELD IN CONFIDENCE

Members of the Association aged 16 or over may complete the form themselves: for girls under 16 the form should be completed by the parent or guardian. *

Name of *unit/event _____

From _____ (date) to _____ (date)

Surname _____

First names _____

Address _____

Postcode _____

Date of birth _____

In an emergency you should contact the following person

Name _____

Relationship _____

Address _____

Postcode _____

daytime evening

mobile _____

Alternative emergency contact

Name _____

Relationship _____

Address _____

Postcode _____

daytime evening

mobile _____

Family doctor: Name _____

Address _____

Postcode _____

daytime evening

Date of anti-tetanus _____

Hospital consultant if applicable: Name _____

Hospital _____

Reg no. _____

*Do you/does she suffer from asthma, chest complaint, wheezing or hay fever, migraine, fits or faints, bad period pains, diabetes, nervous disorders, any other illness or disability? *YES/NO If YES, please give details.

*Are you/is she allergic to anything? (Antibiotics, any particular food or medication etc.) *YES/NO If YES, please give details.

*Are you/is she receiving any medical treatment at present? *YES/NO If YES[†], please give details overleaf. Please also give details of any pills, medicines etc.

[†]And if YES and travelling overseas, please attach a current medical certificate confirming your/her fitness to take part in the event.

Does she administer her own medication? *YES/NO

*Have you/has she had contact with any infectious illnesses within the last month? *YES/NO If YES, please give details overleaf.

*Do you/does she have any faith or cultural needs e.g. dress, diet, holy days, toilet arrangements? *YES/NO If YES, please give details overleaf.

For members aged under 16

Medication required should be given to the Guider-in-charge, or the First Aider, clearly marked with name and full instructions for use. Inhalers and epipens should be retained by the girl. Spare inhalers/epipens given to the First Aider.

The following medication will be available if required. Please indicate which may be used for your child.

*YES/NO

*YES/NO

*YES/NO

*YES/NO

*YES/NO

*YES/NO

EMERGENCY PERMISSION

I authorise _____ (name)

Guider-in-charge

*and/or _____ (name)

First Aider

to give permission for my child to receive medication as instructed above and any emergency dental, medical or surgical treatment, including anaesthetic, as considered necessary by the medical authorities present.

Signed _____

Parent/guardian * _____ Date

Signed _____

Member (if aged 16 or over) _____ Date

PLEASE TURN OVER

