



# Health Form

RF 2

Name of organisation/ event \_\_\_\_\_

Name of participant \_\_\_\_\_

*All information is strictly confidential and should be provided as accurately and as detailed as possible for the child/ young persons' benefit.*

### PERSONAL DETAILS

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Tel: \_\_\_\_\_

### CONTACT 1 (FOR EMERGENCIES) - PARENT OR GUARDIAN

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Tel (Work): \_\_\_\_\_ (Home): \_\_\_\_\_ (Other) \_\_\_\_\_

### CONTACT 2 (FOR EMERGENCIES) – AUTHORISED BY PARENT OR GUARDIAN

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Tel (Work): \_\_\_\_\_ (Home): \_\_\_\_\_ (Other) \_\_\_\_\_

### DOCTOR'S DETAILS

Doctor's name: \_\_\_\_\_ Doctor's address: \_\_\_\_\_

\_\_\_\_\_ Doctor's Tel. No. \_\_\_\_\_

Medical Card No: \_\_\_\_\_

### MEDICAL DETAILS

Can he/she take Paracetamol (Pandol)? Yes  No

Does he/she suffer from any illness? Yes  No

If yes, please state: \_\_\_\_\_

When did he/she last have a tetanus vaccine? \_\_\_\_\_

Does he/she have: impaired hearing?   
impaired vision?   
other disability?  Please specify: \_\_\_\_\_

Does he/she suffer from any allergies? Yes  No

If yes, please state: \_\_\_\_\_

Has he/she had an adverse reaction to an anaesthetic? Yes  No

If yes, please give details: \_\_\_\_\_

**CURRENT MEDICATION**

Is he/she taking any medication/treatment?      Yes       No

(If this form is being used for residential, please ensure that he/she has sufficient for the duration of the stay away.)

Please give detailed instructions below of medication, i.e. details of how much and how often to be taken. If necessary, speak to the leader-in-charge. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specifically for residential:

Does he/she wet their bed?      Yes       No

If so, please bring plastic sheeting, and/or sufficient changes of sheets and nightwear.



In the case of an emergency, leaders will do everything possible to contact either of the contacts listed above, so that they can make the appropriate medical decisions for their child. (N.B. Only in extreme circumstances will leaders make emergency medical decisions on behalf of parents).

I/we give permission for the child/young person named above to take part in all activities NOT EXPLICITLY SPECIFIED. Although supervision will be maintained at all times, I/we understand that there may be some sports or activities that are physically demanding (e.g. swimming, relay racing, rounders, volleyball, football, hockey, hill walking). Please tick.

The following are activities which I/we feel this child/young person should NOT participate in:

Swimming

Ice-skating

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specifically for residential:

I/we are willing for the above named child/young person to attend this residential and will do my/our best to encourage him/her to obey the rules and give the residential leadership their support. Please tick.

Signature: \_\_\_\_\_

Relationship to child or young person: \_\_\_\_\_

Date: \_\_\_\_\_