# Health Information Form

This section is to be completed by the Parent or Guardian of the young person named below. Please answer the following questions as fully as possible. (Please complete in BLOCK CAPITALS)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Surname | | |  | Date of Birth | | |
| Forenames | | |  | Date of last Tetanus injection | | |
|  | | |  |  | | |
| Parent/Guardian Address During the Event      Post Code:    **Telephone: Mobile:** |  | Family Doctors Name and Address        Telephone | | | | |
| ***Please read each question and tick YES or NO as appropriate*** | | | | | **Yes** | **No** |
| Has your child been in contact with any contagious or infectious disease within the last 3 weeks? If YES give details below. | | | | |  |  |
| Has your child suffered from any recent illness? If YES give details below. | | | | |  |  |
| Is he/she allergic to anything? If YES give details below. | | | | |  |  |
| Does he/she suffer from diabetes, migraine, epilepsy or any other illness or disability? If YES give details below. | | | | |  |  |
| Is he/she receiving any medical treatment at present? If YES give details below. | | | | |  |  |
| Is he/she receiving any special dietary needs? If YES give details below. | | | | |  |  |
| Is your child currently taking any medication? If YES give details below. | | | | |  |  |
| Is there any other information of which we should be aware? If YES give details below. | | | | |  |  |
| Continue overleaf for any of the above… | | | | |  |  |

*If it becomes necessary for the above named young person to receive medical treatment and I cannot be contacted to authorise this, I hereby give my general consent to any necessary medical treatment and authorise the Leader in charge to sign any document required by the hospital authorities.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Parent/Guardian |  | Relationship to  Young Person | | |
| Signature | | |  | Date |