

Medical Form

Personal Details

Name: _____
 Address: _____

 _____ Postcode: _____
 D.O.B: _____ Age: _____ Home Tel: _____ Mobile: _____

Person to Contact in Case of Emergency

Name: _____
 Address: _____

 Home Phone: _____ Work Phone: _____ Mobile: _____

Medical Statement

Do you have any condition requiring regular treatment? Yes No
 Do you have any of the following? (If yes, tick the relevant boxes)

Any major illness <input type="checkbox"/>	Recent injuries / operations <input type="checkbox"/>
Blackouts / headaches / Migraine / Dizziness <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Allergies to bites / food / medicine <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Asthma / Bronchial Illness <input type="checkbox"/>	Heart Complaints <input type="checkbox"/>
Pregnancy <input type="checkbox"/>	Back / Neck Complaints <input type="checkbox"/>

Details of any other condition: _____

Details of any medication or dietary needs: _____

*** (PLEASE BRING MEDICATION / INHALERS WITH YOU ON THE DAY) ****

- I consent to emergency medical treatment being given if deemed necessary during the course of these activities. Yes No
 - I can swim 50m (i.e. 2 lengths of a swimming pool) Yes No

Name of Doctor: _____
 Address: _____
 _____ Tel: _____

Declaration

I the undersigned give permission for _____ to take part in any activities run as part of the U.A.C.F. Youth Programme. To the best of my knowledge the details supplied above are correct.

SIGNED: _____ DATE: _____

By participants if over 18, if under 18 by Parent / Guardian