

**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**