

Event medical questionnaire

SJF 26 (Youth)



IN CONFIDENCE when completed

Please complete and return this form in an envelope marked private and confidential to the Event Organiser:

In the interests of safety, please note that the Course Director/Warrant Holder will need to see these details if the participant is taking part in a residential/camping or adventurous events. However this form will be treated as confidential.

1. Event details (to be completed by Event Organiser)	
Event:	
Location:	
Date/Time from:	
Date/Time to:	

2. Participant details	
Surname:	
First name:	
Preferred first name:	
Male / Female:	Date of birth:
Home address including postcode:	
Home telephone no:	
E-Mail:	
SJA unit:	Religion:

3. Next of kin details	
Name:	
Relationship:	
Home address (if different from above):	
Contact numbers (day & night):	

4. Alternative / emergency point of contact (eg if the next of kin cannot be contacted)	
Alternative contact name and address:	
Alternative phone no:	
Relationship:	
Under what circumstances should this person be contacted:	

5. Dietary requirements
Please give details of ALL special dietary requirements or food allergies:

6. Medical details of the participant
NHS number*: Name of GP (Doctor): Address, telephone and FAX number of surgery:

* This number can be obtained from your GP

Has the above named participant any disabilities, medical conditions (i.e. epilepsy, diabetes, asthma), allergies or had any illness/injury within the last month? Please list below and include details of any medications currently used that will be taken to the event (drug name/s and dosage):

Date of last tetanus immunisation:	
Is the participant currently, or have they within the last three months received medical/surgical treatment? If so, please give details:	
Has the participant been given specific medical advice to follow or has specific medication to take in an emergency? If so, please give details:	

- Continue on a separate sheet if necessary

7. Applicable to participants under 16 years of age

a) Medical permission
Please tick the appropriate box:

My child can administer their own medications	YES		NO	
My child will need assistance to administer their own medications	YES		NO	

b) Medical support at residential/camping events
In the event of your child suffering from a common ailment, would you agree to the following medications being offered to your child? Please indicate below:

Paracetamol	YES		NO		Wasp-Eze spray	YES		NO	
Ibuprofen	YES		NO		Simple Linctus	YES		NO	
Piriton / Chlorpheniramine	YES		NO						

Please use this space to note any other areas of the participant's health and welfare that we should be aware of: (For example: Colour Blindness; Dyslexia; Autism; Asperger's Syndrome, etc).

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I undertake to advise the event organiser, in writing, of any changes to information on this form (including medical treatments) before the date of the event.

The details given on this form are complete and correct	
Signed: Name in print: (By person who has parental responsibility if participant is under 16):	Date: