 Confidential

# Health Form

**To be completed by OIC or nominated person**

Event Type Activity/Residential

Name of Event Kingswood 125th Anniversary Start Date\_6th Oct 2017\_ End Date \_8th Oct 2017\_

Person Responsible for First Aid at the event CLCGB Appointed Persons\_

**To be completed by**

* **Parent/Guardian of members under 16.**
* **Members aged 16+**
* **Adult Officers/Leaders/Helpers/Volunteers**

**NB If any adult would prefer not to disclose confidential information, please supply a fully completed health form in a sealed envelope that will be opened only in the event of an emergency.**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode \_\_\_\_\_\_\_\_\_\_\_\_

GP’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post Code \_\_\_\_\_\_\_\_\_\_\_\_

GP’s Tel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Medication** The following medication/first aid supplies will be available. Please indicate which may be given/ used if required by the participant:  |
|  | Paracetamol/Aspirin/Ibuprofen |  | Plasters |
|  | Antiseptic Cream |  |  |
|  | Constipation/Diahorrea Relief |  |  |
|  | Insect repellent/Bite cream/Sun Cream |  |  |
| Does the participant have any special instructions on the use of the medication or first aid available? |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Allergies** Does the member have any allergies?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

Please give precise details and indicate severity.  |
| **Medication (personal)**Is the member currently taking medication or receiving medical treatment?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

Please give precise details. Does the member self medicate?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

Please indicate which medicines are self administered.Date of last known tetanus injection if known. |
| **Injuries illnesses and disabilities** Does the member have any injuries, illnesses or disabilities relevant to the event/activities?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

Please give precise details. **Bedwetting**Does the member have any bed wetting issues. We ask this so support may be available and this will be strictly confidential.

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

  |

**Note**

**All medication needs to be labelled with the members name and required dosages.**

**All medication is to be signed in to the First Aid Officer.**

**Please supply spare inhalers and epipens to be held by the First Aider.**

**Emergency Contact Information**

Please give information of at least two people that will be contactable throughout the event.

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Name |  |
| Telephone 1 |  | Telephone 1 |  |
| Telephone 2 |  | Telephone 2 |  |
| Relationship |  | Relationship |  |

**Consent**

I authorise the Leaders and First Aiders present at the event to give permission for my child to receive any emergency treatment including anaesthetic, as considered necessary by the medical authorities.

|  |  |
| --- | --- |
| Parent/Guardians’s Name |  |
| Paren/Guardiant’s Signature |  | Date |  |