SEC Area 8

Basildon Pathfinder Club
17 Jersey Gardens
Wickford, SS11 7AG

Medical Form

Child's Name _____ Birth Date ___/___/_____ Age ___
Parent's/Guardian's Name(s) _____
Address _____ City _____
County_____ Postcode _____ Home Phone _____
Emergency Phone _____ Church _____
School _____ Date of Registration ___/___/_____

Medical Details:

☑=YES ☒=NO

Have you had:		**Do you wear:**	
Rheumatic fever:	❑	Glasses:	❑
Asthma:	❑	Contact lenses:	❑
Fainting spells:	❑	Dentures:	❑
Diabetes:	❑		
Kidney Disease:	❑	**Are you allergic to:**	
Heart trouble:	❑	Penicillin:	❑
Menstrual problems:	❑	Anaesthetic:	❑
Hernias:	❑		
Travel sickness:	❑	Tetanus injection in last 5 years?	❑

Please give the date of the last tetanus injection __/__/__.

If you are currently taking medicine please give the name of the drug and dosage details

_____

Do you have any food allergies?_____

Name of GP/Doctor _____ Surgery_____
Address _____ City _____
County_____ Postcode _____ GP/Doctor Phone _____
NHS Number _____

Other Information

If there is anything else that should be considered by the club, relating to the health and/or ability of the above mentioned person, please state clearly below:

_____
_____
_____

Authorisation

This health report is correct as far as I know, and the person described has permission to engage in all prescribed activities, except as noted by me. In the event of an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalise or treat including proper anaesthesia, injection, or surgery for the person this form applies to.

_____
signature of Parent/Guardian