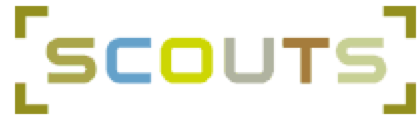
Group name:………………………….
S.L:……………………………………



HEALTH INFORMATION

Scout details

Surname…………………………
Forenames………………………..
Address…………………………..
……………………………………
…………………………………….
Post code…………………………
Date of birth………………………
National Health
Number……………………

Family Doctor's Name and Address

Name …………………………………..
Practice…………………………………
Address…………………………………
…………………………………………..
Post code……………………………….
☎…………………………………………

In an emergency you should contact the following

Name………………………………………
Relationship……………………………….
Address…………………………………….
Postcode…………………………………..
☎Daytime…………………………………
☎Evening………………………………….
☎Mobile……………………………………

Alternative emergency contact

Name……………………………….
Relationship…………………………
Address…………………………….
Postcode……………………………..
☎ Daytime………………………..…
☎ Evening ………………………….
☎ Mobile……………………………

If it becomes necessary for my child to receive medical treatment and I cannot be contacted by phone or any other means to authorise this, I give my general consent to any necessary medical treatment and authorise the organiser in charge to sign any document required by the hospital authorities.

Name of Parent/Guardian…………………………………………..Relationship…………………………………………………..

Signature of Parent/Guardian……………………………………..Date…………………………………………………………………

Please mark as appropriate. whether or not your son / daughter suffers from or can /can't have

	CAN	CAN'T
Elastoplast	☐	☐
Aspirin	☐	☐
Paracetamol	☐	☐
Penicillin	☐	☐
Ibuprofen	☐	☐

	YES	NO
Diabetes	☐	☐
Hay fever	☐	☐
Asthma	☐	☐
Wasp/bee sting	☐	☐
Epilepsy	☐	☐

Please indicate any thing else you feel we need to know about along with dietary needs eg. allergies
……………………………………………………………………………………………….
Does you son/daughter administer their own medicine when required? YES/NO and if so for what do they administer this?…………………………………………………………………………