

PLEASE RETURN	THIS FOR	M, COMP	LETED AND	SIGNED,	TO	THE
GUIDER-IN-CHARG	GE ON				(D.	ATE)

	.			
	CLICK ON EACH LINE AND TYPE IN THE DETAILS. SELE	CT STARRED(*) ITEMS FROM EACH DROP-DOWN MENU AS APPROPRIATE.		
NOTE: THIS INFO	ORMATION WILL BE HELD IN CONFIDENCE	*Are you/is she receiving any medical treatment at present? *YES/NO If YES¹, please give details overleaf. Please also give details of any		
	ociation aged 16 or over may complete the form themselves: rm should be completed by the parent or guardian. * ent			
From	(date) to (date)	e) †And if YES and travelling overseas, please attach a current medical		
	[44.5]	certificate confirming your/her fitness to take part in the event.		
Surname		Does she administer her own medication? *YES/NO		
First names Address		_		
Addiess		*Do you/does she had contact with any infectious illnesses within the		
	Postcode	last month? *YES/NO If YES, please give details overleaf.		
Date of birth				
In an emergency	you should contact the following person			
Name		*Do you/does she have any faith or cultural needs e.g. dress, diet, holy days toilet arrangements? *YES/NO If YES, please give details overleaf.		
Relationship				
Address		_		
	Postcode	- -		
	€ evening	For members aged under 16		
		Medication required should be given to the Guider-in-charge, or the		
Alternative emerg	jency contact	First Aider, clearly marked with name and full instructions for use.		
Name Relationship		Inhalers and epipens should be retained by the girl. Spare inhalers/epipens given to the First Aider.		
Address		-		
71441000	Doctordo	The following medication will be available if required. Please indicate which may be used for your child.		
€ daytime	Postcode & evening	-		
© mobile	€ CVCIIIII	*YES/NO		
		*YES/NO		
Family doctor: Na	ıme	*YES/NO		
Address		- \ *YES/NO		
	Destrode	*YES/NO		
@ doubline	Postcode			
		EMERGENCY PERMISSION		
Date of anti-tetan	us	_ _		
Hospital consultar	nt if applicable: Name	_ authorise (name		
Hospital		Guider-in-charge		
Reg no.	C			
*Do vou/does she	e suffer from asthma, chest complaint, wheezing or	*and/or (name		
•	ne, fits or faints, bad period pains, diabetes, nervo	First Aider us		
	ner illness or disability? *YES/NO If YES, please	to give permission for my child to receive medication as instructed above and any emergency dental, medical or surgical treatment, include		
give detailer		ing anaesthetic, as considered necessary by the medical authorities present.		
		— Signed		
		Parent/guardian * Date		
•	llergic to anything? (Antibiotics, any particular food			
or medication etc.	.) *YES/NO If YES, please give details.	Signed		
		Member (if aged 16 or over) Date		
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		PLEASE CHECK THE NEXT PAGE IF YOU ARE TRAVELLING OVERSEAS		

FOR THOSE TRAVELLING OVERSEAS ONLY	Please check with your doctor which immunisations are required for the country or countries *You/she will be visiting. Please list those
Country to be visited	received, with dates.
Event	
Reference no.	Poliomyelitis Date
	Others (please specify) Date
*Have you/has she visited a doctor for any reason at all during the past six months? *YES/NO If YES, please give details.	
Please note that it may be necessary to obtain a medical certificate confirming that you are fit to travel.	NB. If travelling abroad, members who wear glasses/contact lenses are advised to carry a spare pair and/or prescription details.
Further details	