MEDICAL FORM FOR PARTICIPANTS ATTENDING A RESIDENTIAL VISIT AT THE ENTRUST OUTDOOR EDUCATION CENTRES

To be completed not more than fourteen days prior to the visit start. For participants under 18 years of age a parent, or person with parental responsibility, must complete this form.

Name of participant..... Date of Birth .....

Address.....

..... Home Telephone No. .....

Name of parent or contact(s).....Relationship .....

Work Telephone No. ..... Mobile Telephone No. .....

Name of Participant's Doctor .....

Doctor's Address & Telephone Number .....

.....

Name of school/establishment.....

IF THE ANSWER TO ANY OF THESE QUESTIONS IS 'YES' PLEASE GIVE FULL DETAILS OVERLEAF (Please circle the appropriate answer)

1. Will the participant need to bring any medications for treatment during the visit?	YES	NO
2. Has the participant suffered from, or been in contact with anyone suffering from, an infectious or contagious disease in the last four weeks?	YES	NO
3. Does the participant suffer from?		
a) Epilepsy	YES	NO
b) Diabetes	YES	NO
c) Asthma	YES	NO
d) Bedwetting	YES	NO
e) Allergies (including to any medication)	YES	NO
4. Is there any condition that may restrict, or be aggravated by, physical activities?	YES	NO

Has the participant received an anti-tetanus injection? If 'yes' give date .....

I hereby give permission for the participant to receive, if necessary, the following proprietary medications, at a dose appropriate to their age, to alleviate these complaints:

1. For colds causing congestion	Decongestant Lozenge (e.g. Tunes)
2. For headache	Paracetamol or Calpol
3. For insect/plant bites or stings	Proprietary spray or cream
4. For sore lips	Lip salve or Vaseline
5. For sun protection	Sunscreen

I agree to the participant receiving medication as instructed and any emergency dental, medical or surgical treatment including anaesthetic or blood transfusion as considered necessary by the medical authorities. I declare that I have answered all the above questions to be best of my ability and have not knowingly withheld any information regarding physical fitness. I undertake to inform the leader in charge of any changes to the above between the date signed and the start of the visit.

..... **Date** .....
Sign and Print Name (Parent/Parental Responsibility Holder if participant is under 18 years)

This medical form must be returned to the visit leader and will be taken on the visit. The data provided will be used to ensure the appropriate care and treatment of participants. The data will be shared with health professionals where necessary.

THIS SECTION TO BE COMPLETED ONLY IF THE ANSWER TO ANY QUESTION OVERLEAF IS 'YES'

1. Give details of any medical treatment needed during the visit or medications that need to accompany the participant (e.g. Hayfever remedies). If regular medication is needed please ensure that sufficient is provided to last throughout the visit.

2. Nature of infectious disease and how contacted during the past four weeks:

3. If the participant suffers from EPILEPSY, DIABETES, ASTHMA, please give FULL details below. These should include severity and frequency of attack, approximate date of the last attack and details of any medication taken regularly or kept for emergencies. (Confirmation of fitness to attend, from a doctor, may be required before affected participants are deemed suitable to attend some visits):

4. Bed-wetting – arrangements must be made by the person with parental responsibility to provide suitable bedding, which may be necessary in this event.

5. Condition causing restriction upon, or that may be aggravated by, physical activities and relevant details (Confirmation of fitness to participate, from a doctor, may be required in certain cases):

6. Details of allergies, including reaction to painkillers, antibiotics, analgesic and other proprietary medicines and reactions to types of food e.g. nuts.