



HEALTH AND MEDICAL RECORD FORM

This form is to be completed by every Staff member and leader.

Name : _____

Date of birth : _____

Address : _____

In case of emergency, notify :

Name : _____

Relationship : _____

Address : _____

Phone number : _____

Mobile phone : _____

Please give details of any current / past relevant medical conditions : _____

Please state any medication you are currently taking :

Do you wear contact lenses? Yes 0 No 0

Are you allergic to anything? Yes 0 No 0

If so, please specify : _____

Are you on a diet? Yes 0 No 0

If so, please specify : _____

Please turn over.

Please give details of your health insurance (insurance number and company) :

This health report is correct as far as I know. In the event the emergency contact cannot be reached in an emergency, I hereby give permission to the physician selected by the camp doctor or leaders in charge to hospitalise or treat, including proper anaesthesia, injection or surgery.

Signature

Date