

SOMERSET YL TRAINING WEEKEND

26-27 January 2019

HEALTH & CONSENT FORM

Camp Leader:

Peter Sampson, ACC (14-25)

This section is to be completed by the Parent or Guardian of the young person named below. Please answer the following questions as fully as possible. In the event of your child requiring emergency treatment, it will help the medical authorities in deciding which is the most appropriate treatment to give.
(Please complete in BLOCK CAPITALS)

Surname:

Name of Unit and Group attached to:

Name of District:
Moors & Coastal / East Somerset / Blackdown
(delete as appropriate)

Forenames:

Date of Birth:

Next of kin: Relationship:

Date of last Tetanus injection:
NHS number:

Parent / Guardian Address & Postcode:
.....
.....Email
address.....
Telephone:

Contact details of next of kin if different during the camp:
.....
.....
.....
.....

Family Doctor's Name and Address:

Telephone:

Please attach a recent photo of the Explorer Scout for whom this form is submitted

NB: The Scout Association may put some or all of the information supplied onto a computer

He / She may have photos taken whilst at the Moot to promote the good publicity of Scouting. These may be published on the Somerset Scout County website

Yes No

I hereby give permission for my child to attend the **SOMERSET YL TRAINING WEEKEND 26-27 January 2019** and to participate in the activities offered.

If it becomes necessary for my child to receive medical treatment and I cannot be contacted immediately to authorise this, I hereby give my general consent to any necessary medical treatment and authorise the Camp Leader, Peter Sampson (or his deputies), to sign any document required for treatment.

I will inform the Camp Leader if any of the information given on this form changes before the event takes place.

The person named above may / may not be given* preparations from the general sales or pharmacy list of medicines for minor ailments e.g. Paracetamol

**Please delete as applicable*

In the space below, please give details of the following:-

1. Any known Infectious Diseases with which your Child has been in contact within the last three weeks (e.g. Chicken Pox, Diphtheria, Measles, Mumps, Rubella, Whooping Cough etc.)
2. Any known Allergies/Sensitivities/Disabilities and details of any known precautions or remedies (e.g. Penicillin, Nut allergies, Food Colourings, Travel Sickness, Bed-Wetting, Asthma etc.)
3. Details of any Medicines/Diets/Treatments currently being taken/followed (including dosage details) & the Specialist and Hospital concerned if appropriate (please include any non prescription preparations, such as cough sweets, herbal medicines).

/ she has to take any medication, the containers should be clearly labelled with their name and the exact dosages, and a leader is made aware on arrival on arrival. It is likely to be most appropriate to hand them in)

Please continue on a separate sheet if required (Remember to include your Son / Daughter's name and attach it securely to this form)

THIS FORM MUST BE SIGNED BY THE PARENT/GUARDIAN



Health Information & Consent Form

Name of Parent/Guardian:

Relationship to Young Person:

Signature:

Date: