**YOUTH EVENT MEDICAL FORM.**

Deep Sleepover on 1st or 2nd December 2023

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SECTION 1 – FULL NAME: | | | | NAME: | |  | | |
| ADDRESS (Including postcode): | | | | DATE OF BIRTH: | |  | | |
| SEX: | | Male Female Prefer not to say | | |
| HOME PHONE: | |  | | |
|  | | | | RELIGION: | |  | | |
| SECTION 2 – EMERGENCY CONTACTS: | | | |  | | | | |
| Parent/ Carer 1. | | | | Parent/ Carer 2. | | | | |
| Name |  | | | Name | |  | | |
| Relationship |  | | | Relationship | |  | | |
| Address |  | | | Address | |  | | |
| Home phone no. |  | | | Home phone no. | |  | | |
| Mobile Phone. |  | | | Mobile no. | |  | | |
| E-mail address |  | | | E-mail address | |  | | |
| Alternative contact. | | | |  | | | | |
| Name | |  | |  | | | | |
| Relationship |  | | |  | | | | |
| Address |  | | |  | | | | |
| Home phone no. |  | | |  | | | | |
| Mobile Phone. |  | | |  | | | | |
| E-mail address |  | | |  | | | | |
| SECTION 3 – DIETARY REQUIREMENTS | | | |  | | | | |
| Please give details of any dietary requirements or food allergies in the space below. | | | |  | | | | |
|  | | | |  | | | | |
| SECTION 4 – MEDICAL INFORMATION | | | |  | | | | |
| Family Doctor: | | | | Is your child being treated by a hospital? | | | | |
| Address ( Including postcode):  Telephone: | | | | **Hospital name:** | |  | | |
| **Department:** | |  | | |
| **Consultant:** | |  | | |
| **Telephone no.:** | |  | | |
| Does your child suffer from any of the below: - | | | | MEDICINES CONSENT | | | | |
| Asthma | | Yes | No | Paracetamol  Gripe water for indigestion.  Anti-histamine cream.  Elastoplast.  Hypo-allergenic plasters.  Antiseptic wipes or baby wipes | | | Yes  Yes  Yes  Yes  Yes  Yes | No  No  No  No  No  No |
| Chest complaint | | Yes | No |
| Wheezing or hayfever | | Yes | No |
| Migraines | | Yes | No |
| Fits or faints | | Yes | No |
| Diabetes | | Yes | No |
| Nervous disorder | | Yes | No |
| Bedwetting | | Yes | No |
| Any other disability | | Yes | No |
| Any allergies to medication/ drugs. | | Yes | No |
| Prone to sleepwalking | | Yes | No |  | | |  |  |
| If you have answered YES to any of the above, please give full details below (continue overleaf if necessary). | | | | **EMERGENCY CONSENT:** | | | | |
|  | | | | If it becomes necessary for my child to receive medical treatment and I cannot be contacted by telephone or any other means to authorise this; I hereby give my general consent to any necessary medical treatment and authorise the section Leaders to sign any document required by hospital authorities. | | | | |
|  | | | | Signed: |  | | | |
| Date: |  | | | |