**ADULT 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: | | | |  | | | | | |
| Spouse/ Partner/ Family Member etc. | | | |  | | | | | |
| Name |  | | |  | | |  | | |
| Relationship |  | | |  | | |  | | |
| Address |  | | |  | | |  | | |
| Home phone no. |  | | |  | | |  | | |
| Mobile Phone. |  | | |  | | |  | | |
| 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: | | | | Are you being treated by a hospital? | | | | | |
| Address ( Including postcode):  Telephone: | | | | **Hospital name:** | |  | | | |
| **Department:** | |  | | | |
| **Consultant:** | |  | | | |
| **Telephone no.:** | |  | | | |
| Do you 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 |
| 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: |  | | | | |