**ADULT EVENT MEDICAL FORM.**

Deep Sleepover on 1st or 2nd December 2023.

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| 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 | ParacetamolGripe water for indigestion.Anti-histamine cream.Elastoplast.Hypo-allergenic plasters.Antiseptic wipes or baby wipes | YesYesYesYesYesYes | NoNoNoNoNoNo |
| 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: |  |