



**Pegasus Explorer Scout Unit
Doncaster Danum District**



**CONSENT AND HEALTH INFORMATION FORM FOR SCOUT
ACTIVITIES AND CAMPS**

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE THE ACTIVITY

| | |
|---|----------------|
| Scouts Full Name: | Date of Birth: |
| | Religion: |
| Address: | |
| Telephone No (incl. code): (01) | |
| Emergency Contact Name: | Relationship: |
| Emergency Contact Address (during event): | |
| Telephone No (incl. code): (01) | |
| <i>NAME OF ACTIVITY</i> | |
| | |

| | | |
|---|-----------------------|--|
| <i>MEDICAL INFORMATION</i> (To be completed by parent/guardian) | | |
| Doctors Name: | | |
| Doctors Address: | | |
| Telephone No (day) (Incl. code): (01) | | Telephone No (night) (Incl. code): (01) |
| HEALTH INFORMATION (It is important to complete this as fully as possible) | | |
| | * delete as necessary | Give details to "YES" answers. |
| Are there any medical or health reasons why he/she should not take part in the activity? | *NO/YES | |
| Has he/she been in contact with any infectious illness in the last 6 months? | *NO/YES | |
| Does he/she suffer from ASTHMA, HAYFEVER, MIGRAINE, FITS, FAINTS, EPILEPSY, DIABETES, or any other ILLNESS or DISABILITY? | *NO/YES | |
| Is he/she taking any form of regular medication? | *NO/YES | |
| Is he/she allergic to ANTIBIOTICS, PLASTERS or any other MEDICINES or FOOD? | *NO/YES | |
| Are there any special DIETARY needs? | *NO/YES | |
| Date of his/her last ANTI-TETANUS injection (if known). | | |

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|---|---------------|
| <i>CONSENT</i> (To be completed by parent/guardian) | |
| I hereby agree to my son/daughter taking part in the above named activity | |
| Should the necessity arise, and I can not be contacted by telephone or any other practical means to authorise urgent medical treatment to the above named, I hereby give my general consent to the Scouter in charge to authorise the medical authorities to give any necessary medical treatment | |
| I understand that the above named will need their own Insurance Cover against damage or loss of personal effects. | |
| I consent to the taking of and, distribution of, any photographic material from this activity. | |
| Signature: | Dated: |
| | |