SCHOOL RESIDENTIALS

MEDICAL QUESTIONAIRE

To be completed by all participants before commencing any activity. This information will be held in confidence by instructors, staff and teaching staff until such time as the information is required:

Name:

....

Age: .... **Sex:** ....

Address:

....

....

....

....

Name, Phone Number & Address of Next of Kin:

....

....

....

....

....

Name, Phone Number & Address of Doctor:

....

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....

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Can you swim (approx. how far)**:**

....

Do you suffer any of the below (tick the box)**:**

- ☐ A Bad Back
- ☐ Asthma
- ☐ Diabetes
- ☐ High Blood pressure
- ☐ Epilepsy
- ☐ Migraine

Are you currently on any medication:

....

Do you have any allergies (inc. Penicillin, Asprin etc.)**:**

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Any other information you feel we require:

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