Health form

Personal information

Full name _____

Preferred name
(what should we call you?) _____

Full address

_____

Phone number _____

Date of birth _____ Gender _____

Health insurance

Company: _____

Policy number: _____

Contact person in case of emergency

Name: _____

Relationship to participant: _____

Phone number : _____

Medical information

Does your son/daughter have a medical or mental health condition? If so, which?

Health form

Does your son/daughter need prescribed medication? If so, specify name and dosage:

_____

Did your son/daughter receive a tetanus vaccination? Yes ☐ No ☐

Does your son/daughter have any allergies? If so, which?

_____

Does your son/daughter have any dietary requirements? If so, which?

_____

Details family doctor / general practitioner (Where applicable)

Name _____

Address

_____

Phone number _____

Signature

In case of a medical emergency I hereby consent to admittance of my son/daughter to a hospital to be treated by an appropriate medical professional. I also consent to the use of the personal details as shared in this form when needed.

Name parent/guardian _____

Date _____

Signature _____