

# Health form



## Personal information

Full name \_\_\_\_\_

Preferred name  
*(what should we call you?)* \_\_\_\_\_

Full address  
\_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Birth date \_\_\_\_\_ 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:

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Did your son/daughter receive a tetanus vaccination?

Yes

No

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

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

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## Details family doctor / general practitioner (Where applicable)

Name

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Address

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Phone number

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## 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

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Date

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Signature

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