

Medical / Contact Form - PLEASE WRITE IN CAPITALS

Your Name:	
Address:	
Telephone:	
Email:	
Wild Day / Camp booked on:	
Name of Child Participating	Male / Female Date of Birth
Adult Contact (in case of emergency)	
Name:	
Relationship to Participant:	
Emergency Phone Number(s):	
Details of Doctor:	
Name:	Phone no.
MEDICAL INFORMATION (please circle answers as appropriate)	
1. Does your child suffer from any conditions requiring medical treatment?	Yes / No
<i>If yes, please give brief details</i>	
2. To the best of your knowledge has your child been in contact with any contagious or infectious diseases in the last 3 months?	Yes / No
<i>If yes, please give brief details</i>	
3. Does your child suffer from any allergies (including medication)?	Yes / No
<i>If yes, please give brief details</i>	
4. Has your child received a Tetanus injection within the last 5-years?	Yes / No
5. Does your child have any special dietary requirements?	Yes / No
<i>If yes, please give brief details</i>	
OTHER INFORMATION	
Is there any additional information we need to know? <i>If so, please give details:</i>	
DECLARATION	
<i>I agree to the children listed on this form receiving medical treatment including anaesthetic as considered necessary by the medical authority present (e.g. paramedic).</i>	
Signature: Date:	