



# Information: general health

PLEASE RETURN THIS FORM, COMPLETED AND SIGNED, TO THE  
LEADER ON \_\_\_\_\_ (DATE)

COMPLETE IN BALL-POINT PEN IN BLOCK CAPITALS. DELETE STARRED \*ITEMS AS APPROPRIATE

NOTE: THIS INFORMATION WILL BE HELD IN CONFIDENCE

Members of Girlguiding UK aged 16 or over may complete the form themselves: for girls under 16 the form should be completed by the parent or carer. \*

Name of \*unit/event \_\_\_\_\_

From \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

Surname \_\_\_\_\_

First names \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Date of birth \_\_\_\_\_

In an emergency you should contact the following person	
Name _____	
Relationship _____	
Address _____	
Postcode _____	
<input type="checkbox"/> daytime	<input type="checkbox"/> evening
<input type="checkbox"/> mobile	
Alternative emergency contact	
Name _____	
Relationship _____	
Address _____	
Postcode _____	
<input type="checkbox"/> daytime	<input type="checkbox"/> evening
<input type="checkbox"/> mobile	

Family doctor: Name \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

daytime  evening

Date of anti-tetanus \_\_\_\_\_

Hospital consultant if applicable: Name \_\_\_\_\_

Hospital \_\_\_\_\_

Reg no.

\*Do you/does she suffer from asthma, chest complaint, wheezing or hay fever, migraine, fits or faints, bad period pains, diabetes, nervous disorders, any other illness or disability? \*YES/NO If YES, please give details.  
\_\_\_\_\_  
\_\_\_\_\_

\*Are you/is she allergic to anything? (Antibiotics, any particular food or medication etc.) \*YES/NO If YES, please give details.  
\_\_\_\_\_  
\_\_\_\_\_

\*Are you/is she receiving any medical treatment at present? \*YES/NO  
If YES<sup>†</sup>, please give details overleaf. Please also give details of any pills, medicines etc.  
\_\_\_\_\_  
\_\_\_\_\_

<sup>†</sup>And if YES and travelling overseas, please attach a current medical certificate confirming your/her fitness to take part in the event.

Does she administer her own medication? \*YES/NO  
\_\_\_\_\_

\*Have you/has she had contact with any infectious illnesses within the last month? \*YES/NO If YES, please give details overleaf.  
\_\_\_\_\_  
\_\_\_\_\_

\*Do you/does she have any faith or cultural needs eg dress, diet, holy days, toilet arrangements? \*YES/NO If YES, please give details overleaf.  
\_\_\_\_\_  
\_\_\_\_\_

**For members aged under 16**

Medication required should be given to the Leader, or the First Aider, clearly marked with name and full instructions for use. Inhalers and epipens should be retained by the girl. Spare inhalers/epipens should be given to the First Aider.

The following medication will be available if required. Please indicate which may be used for your child.

_____	*YES/NO
_____	*YES/NO
_____	*YES/NO
_____	*YES/NO
_____	*YES/NO
_____	*YES/NO

**EMERGENCY PERMISSION**

I authorise \_\_\_\_\_ (name)  
Leader

\*and/or \_\_\_\_\_ (name)  
First Aider

to give permission for my child to receive medication as instructed above and any emergency dental, medical or surgical treatment, including anaesthetic, as considered necessary by the medical authorities present.

Signed \_\_\_\_\_  
Parent/carer \* \_\_\_\_\_ Date

Signed \_\_\_\_\_  
Member (if aged 16 or over) \_\_\_\_\_ Date

PLEASE TURN OVER

\* or other adult with parental responsibility

