



Gradbach Scout Camp

Border HIKE COMMITTEE

HEALTH & CONSENT

PLEASE COMPLETE IN BALL POINT PEN IN BLOCK CAPITALS. DELETE STARRED * ITEMS AS APPROPRIATE.
 NOTE: THIS INFORMATION WILL BE HELD IN CONFIDENCE AND WILL BE DESTROYED AFTER THE HIKE. Details may be continued overleaf or on separate pages if necessary

A form must be completed for every participant by the Parent or Guardian.

Date :- **Border Hike and John Bradbury Trophy 22nd to 24th September 2017**

The Young Person attending the event is:

Surname: _____

First Names: _____

Address: _____

Date of Birth: _____ Gender: * Male/Female

National Health No. (if known): _____

Date of last anti-tetanus injection: _____

Name and address of family doctor:

Name: _____

Address: _____

Postcode: _____

Tel. _____

Parent/Guardian's or Next of Kin's contact details for the duration of the event:

Name: _____

Relationship: _____

Tel. Home: _____

Tel. Mobile: _____

Tel. Work: _____

Name: _____

Relationship: _____

Tel. Home: _____

Tel. Mobile: _____

Tel. Work: _____

Parent/Guardian Agreement is required.

- I hereby give my permission for my son/daughter (as named above) to attend the above event
- I understand that my son/daughter will be the responsibility of Their Leaders during the event and I give my consent for them and the First Aiders to administer the medication as agreed above, at their discretion.
- In the event of an emergency relating to my son/daughter, I understand that the leaders will attempt to contact me as soon as possible. However, in the event that I cannot be contacted, I authorise the Leaders/First Aiders to sign on my behalf any written form of consent required by the hospital authorities in the event of emergency medical treatment being necessary.
- I understand that all activities will be run in accordance with the Policy, Organisation and Rules of the Scout Association and will therefore be run by appropriately qualified personnel.
- I also understand that photographs/video may be taken during the event for promotional purposes therefore if I have an objection to son/daughter being photographed I shall confirm this to the leaders in writing.
- All information provided on this form is correct and up-to-date to the best of my knowledge.

PLEASE INDICATE YOUR CONSENT FOR THE LEADERS/FIRST AIDERS TO MAKE THE FOLLOWING MEDICINES AVAILABLE SHOULD THEY BE REQUIRED, IN ORDER THAT HE/SHE MAY EITHER BE ADMINISTERED A DOSE OR SELF-ADMINISTER A DOSE WITH LEADER SUPERVISION:

Paracetamol (i.e. Calpol/Tablets)	* YES/NO
Ibuprofen (not for asthmatics)	* YES/NO
Antihistamine medication (for allergic reactions)	* YES/NO
Insect bite/sting cream (i.e. Waspeze, Anthisan)	* YES/NO
Fabric Plasters	* YES/NO

Do you have any medical conditions such as the following:

Diabetes ___ Epilepsy ___ Asthma ___ Heart Condition ___

Allergies _____ Access to a Epi Pen * YES/NO

Please provide details of any medication currently being taken: If not applicable, please write 'NONE'

Does the participant self-medicate? * YES/NO

Medication: Please label participant's medication with their name & provide clear instructions for its use(whether or not they self medicate, dosage etc).

Signed: _____ (Parent/Guardian)

Date: _____

PLEASE CONTINUE DETAILS ON REVERSE IF REQUIRED