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|  | **SOMERSET**  **EXPLORER SCOUT MOOT 2018** |
| **Adult Authorisation and Health Form**  **Event Leader: Peter Sampson** |

**This form is to be completed by the person named below. Please answer the following questions as fully as possible as, in the event of you requiring emergency treatment, it will help the medical authorities in deciding which is the most appropriate treatment to give. (Please complete in BLOCK CAPITALS)**

|  |  |  |
| --- | --- | --- |
| Surname |  | Date of Birth |

|  |  |  |
| --- | --- | --- |
| Forenames |  | National Health Service Number |

|  |  |  |
| --- | --- | --- |
| Male / Female |  | Date of last Tetanus injection |

|  |  |  |
| --- | --- | --- |
| Home Address      Email Address........................................................................................... |  | Family Doctors Name and Address        Telephone |

I will be attending the Somerset County YL training 5-7 July 2018

If it becomes necessary for me to receive medical treatment and my next of kin cannot be contacted by telephone or any other means to authorise this I hereby give my general consent to any necessary medical treatment and authorise the Camp leader named above (or in their absence one of the assistant camp leaders) to sign any document required by the hospital authorities.

I will inform the Camp Leader if any of the information given on this form changes before the event takes place

I understand that my photograph may be taken whilst taking part in this activity to promote the good publicity of scouting.

## Please tick this box if you DO NOT wish for this to happen. □

|  |  |  |  |
| --- | --- | --- | --- |
| Next of kin | Relationship |  | Contact telephone during event |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature | Contact telephone number during the camp Mobile |  | Date |

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| The person named above \*may/may not\* be given preparations from the general sales or pharmacy list of medicines for minor ailments e.g. Paracetamol, Piriton, Ibuprofen. \*Please delete as applicable |
| In the space below please give details of the following:-  1. Any known infectious diseases with which you have been in contact within the last three weeks (e.g. Chicken Pox, Diphtheria, Measles, Mumps, Rubella, Whooping Cough etc.)  2. Any known allergies/sensitivities/disabilities and details of any known precautions or remedies  3. Details of any medicines/diets/treatments currently being taken/followed (including dosage details) & the specialist and hospital concerned if appropriate            Please continue on a separate sheet if required (remember to include your name on any separate sheets and attach them securely to this form) |