



The Scout Association of Malta Fgura Scout Group

Health Form

Please complete and return

CONFIDENTIAL

Name of Member:		Date of Birth:	
Name of Activity:		Date of Activity:	
Mother's Name:		Father's Name:	
Blood Group:		Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Address		Locality	
		Post Code	
Home Tel No.:		Family Doctor Name:	
Mobile:			
Work Tel No.:		Tel No.:	
Other Information:			

Medical History				Allergies or Reactions to:
Is the member now, or has he ever been treated for any of the following:				
Yes	No	Condition	Explain	Medications; Food, Plants, or Insect Bites;
		Diabetes		
		Ear/Sinus problems		
		Muscular/skeletal condition		
		Psychiatric/psychological/emotional difficulties		
		Learning disorders (i.e. ADHD, ADD)		
		Bleeding disorders		
		Fainting spells		
		Seizures		
		Surgery		
		Serious Injury		
		Other		

Medications		
List all medications currently used. (Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only)		
Medication _____	Medication _____	Medication _____
Dose _____ Frequency _____	Dose _____ Frequency _____	Dose _____ Frequency _____
Reason for medication _____	Reason for medication _____	Reason for medication _____

Member's name	_____
Member's signature (if over 16yrs)	_____
Parent/guardian name	_____
Parent/guardian signature	_____
Date:	_____