



Fgura Scout Group - Health Form

Member's Name & Surname	Date of Birth:
Name of Activity/Event:	Start and End Date of Activity/Event
Mother's Name	Father's Name
Mother's Mobile No:	Father's Mobile No:
Blood Group (If known)	Home Tel No:
Address of Current Residence:	
Any other information you think may be relevant:	

Medical History Is the member now, or have they ever been treated for any of the following:	Known Allergies or Reactions to:																																												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> <th style="width: 50%;">Condition</th> <th style="width: 30%;">Explain</th> </tr> </thead> <tbody> <tr><td></td><td></td><td>Diabetes</td><td></td></tr> <tr><td></td><td></td><td>Ear/Sinus Problems</td><td></td></tr> <tr><td></td><td></td><td>Muscular/skeletal condition</td><td></td></tr> <tr><td></td><td></td><td>Psychiatric/ psychological/ emotional difficulties</td><td></td></tr> <tr><td></td><td></td><td>Bleeding disorders</td><td></td></tr> <tr><td></td><td></td><td>Fainting spells</td><td></td></tr> <tr><td></td><td></td><td>Seizures</td><td></td></tr> <tr><td></td><td></td><td>Recent Surgery (Within the past 24 months)</td><td></td></tr> <tr><td></td><td></td><td>Serious Injury</td><td></td></tr> <tr><td></td><td></td><td>Other</td><td></td></tr> </tbody> </table>	Yes	No	Condition	Explain			Diabetes				Ear/Sinus Problems				Muscular/skeletal condition				Psychiatric/ psychological/ emotional difficulties				Bleeding disorders				Fainting spells				Seizures				Recent Surgery (Within the past 24 months)				Serious Injury				Other		Medications: Food, Plants, Insect Bites, etc...
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Medications List all medications currently used. (Inhalers and EpiPen information must be included, even if they are for occasional emergency use only). If the child has an asthma nebuliser mask they are to bring it with them if the event is a camp (even if it they normally use it very rarely)		
Medication: _____ Dose: _____ Frequency: _____ Reason for medication: _____	Medication: _____ Dose: _____ Frequency: _____ Reason for medication: _____	Medication: _____ Dose: _____ Frequency: _____ Reason for medication: _____

COVID-19 Vaccination Due to the current worldwide COVID-19 Pandemic, we will be keeping track of which members present at the activity have been vaccinated. This will facilitate contact-tracing efforts in the case of an outbreak during the activity itself. Vaccinated members may be asked to show their vaccination certificate at the start of the activity. Has your son/daughter been vaccinated against COVID-19? YES _____ NO _____ If your answer is "YES" please indicate the date when s/he received the last dose: DD-MMM-YYYY
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By signing this form I hereby consent that, for the duration of the activity: a. The Group's leaders or any assisting adult members may seek medical assistance for my son/daughter should this be required in an emergency situation. b. Medical professionals may examine and treat my son/daughter, should this be required in an emergency situation. c. Relevant contact details may be shared with the national health authorities in the case of an outbreak of disease during the activity. In any of the above cases the Group will make every effort to contact the parents using the contact details provided on this form as quickly as possible
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Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Date: _____ Time: _____