

Adult health form

This information will be kept confidential and only used in the event of accident or illness.

Name :

Date of Birth:

Address :
.....
.....

Scout Group:.....

Current Medication:

.....
.....

Please give information of any allergies that you may have:

.....
.....

Please give information on any health concerns you may have:

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.....
.....

1st Emergency contact number - Name:

Address & Phone Number :

2nd Emergency contact number - Name:

Address & Phone Number :

If it becomes necessary for me to receive medical treatment & I am not able, I hereby give my general consent to any necessary medical treatment and authorise

..... (give name) to sign any documentation necessary on my behalf.

Name :.....

Signature :.....