



# Award Scheme Expedition Health Information & Activity Form

This section (both sides) is to be completed by the Parent or Carer of the person named below or by the Adult in the case of Leaders attending. Please answer the following questions as fully as possible as in the event of you or your child requiring medical or emergency treatment, it will help the medical authorities in deciding which is the most appropriate treatment to give. Please include details of any condition that may effect you or your son or daughter whilst at this Activity. This information will be treated in the strictest confidence. (Please complete in BLOCK CAPITALS)

Surname

Date of Birth

Forenames

National Health Service Number

Does the person named above have any medical condition that may effect them whilst on this activity Yes  No  (if YES please give details on reverse)

Date of last Tetanus injection

Next of Kin Address During the Activity

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Telephone Home.....

Mobile .....

Work.....

Family Doctors Name and Address

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Telephone .....

I hereby formally give permission for the person named above to attend the Expedition weekend.

If it becomes necessary for my son/daughter to receive medical treatment and the 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 Leader (or in their absence one of the Assistant Leaders), to sign any document required by the hospital authorities. I will inform the Leaders if any of the information given on this form changes before the event takes place.

Name of Next Of Kin

Relationship to Person named on this Form

Signature

Date

The First Aiders may administer the appropriate minor treatment/precautions (as listed below ) if required.

Headache/general pain (e.g. Paracetamol) .....

Stomach Upset .....

Colds etc (e.g. Lemsip). .....

Is the person named on this form vegetarian Yes  No

In the space below please give details of the following:-

- 1. Any Known Infectious Diseases with which the person named on this form has been in contact within the last three weeks (e.g. Chicken Pox, Diphtheria, Measles, Mumps, Rubella, Whooping Cough etc.)
- 2. Any Known Allergies/Sensitivities/Special Needs/Medical Conditions and details of any known precautions or remedies (e.g. Penicillin, Food Colourings, Travel Sickness, Bed-wetting, Asthma, any special needs etc.)
- 3. Details of any Medicines/Diets/Treatments currently being Taken/Followed (including dosage details) & the Specialist and Hospital concerned if appropriate (please include any non prescription preparations, such as cough sweets , herbal medicines).

*(If you/your son or daughter has to take any Medicine's, the bottle(s), jar(s) or other items should be clearly labelled with their name and the exact dosages, and in the case of Young People should be handed to a Leader before departure. If your child uses an inhaler one should be kept by them and a spare, labelled with their name, handed to a Leader.)*

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Please continue on a separate sheet if required (Remember to include your child(s) name on any separate sheets and attach them securely to this form)

**Activity Authorisation**

ALL activities will be carried out in accordance with the relevant activity rules as laid down by the Scout Association. Adventurous Activities have by their very nature an element of risk. These activities are made as safe as possible through the awareness and vigilance of the adults and participants who take part in them.

We ask that ALL participants work within the guidelines that they are given and they help us by informing us if they are at all anxious or concerned about any part of the activity.

I confirm that the person named on this form can take part in the following activities:-

**Expedition Training/Assessment from the ...../...../..... to the ...../...../.....**

I confirm that my son/daughter can take part in the above activities. I accept that these activities have by their nature an element of risk involved in them. I am aware that the risk is managed through the training and awareness of the Leaders who will run the activities.

Signed ..... Date...../...../.....  
(Parent/Carer/Next of Kin of Person Named on this form)