



MEDICAL DETAILS



PLEASE COMPLETE THE FOLLOWING INFORMATION

NAME	DOB / /
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YOUR CONTACT NUMBERS

Your emergency contact details during your stay with us are:

NAME OF PARENT /GUARDIAN/CONTACT ETC	
ADDRESS OF PARENT/GUARDIAN/CONTACT ETC	EMAIL
	HOME TEL NO.
	FAMILY DOCTOR'S NAME
POSTCODE	DOCTOR'S TEL NO.

MEDICAL DETAILS

Please indicate with a tick if you suffer from any of the following:

ALLERGY <input type="checkbox"/>	ASTHMA <input type="checkbox"/>	EPILEPSY <input type="checkbox"/>	OTHERS Please specify	
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None of the above will exclude you from participating in Project 32. The information is needed to enable us to make the appropriate arrangements for your stay.

Please give details of any medicine that you are currently taking and how often it has to be taken.

MEDICAL CONDITION	MEDICATION REQUIRED	HOW OFTEN YOU TAKE IT

Do you have any special needs or requirements? Please give details. eg disability, dietary requirements etc.

Please note that we are not permitted to dispense any non-prescribed medication, e.g. paracetamol or other painkillers, so if you wish you to have access to painkillers in the event of a headache, for example, then they should be brought with you at your personal responsibility.

PLEASE COMPLETE THE FOLLOWING BY TICKING YOUR ANSWER:

Are you allergic to Penicillin?

YES NO

Have you had an anti tetanus injection in the last 10 years?

YES NO

Have you been in contact with any infectious diseases during the past 3 weeks?

YES NO

IF YES, PLEASE GIVE DETAILS :

Please include this form with your application.