HEALTH & Permission FORM

This form will be held confidentially and stored securely. All information is provided for the purpose of ensuring safe scouting activities.

Forms will be retained until two weeks after the event named. This form will then be destroyed securely unless it pertains to any incident or happening on the listed events, where this form will provide material evidence of permissions specified and details provided, whereupon in accordance with The Scout Association policy and for provision of litigation, the form will be retained until five years after the incident or five years after the young person’s twenty-first birthday whichever is the later, any such retention will be notified to you.

The medical profession takes the view that the parent’s or carer’s consent to medical treatment cannot be delegated. This view is explicit in The Children’s Act 1989. Thus, medical consent forms have no legal status and a doctor or nurse insisting on the consent of a parent or carer to a particular treatment has the right to do so. However, it can be a comfort to medical staff to have general consent in advance from parents or carers or to have a Leader on hand able to sign forms required by medical authorities.

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| **(1) Member Basic Information** | |
| Surname | |
| First names | |
| Address | |
|  | |
|  | Postcode |
| Date of birth | |

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| --- | --- | --- |
| **(2) Emergency Contact Information** | | **1** |
| Name | | |
| Relationship | | |
| Telephone | Mobile | |
| **(2a) Alternative Emergency Contact** | | **2** |
| Name | | |
| Relationship | | |
| Telephone | Mobile | |

|  |  |
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| **(3)** **Family Doctor** | |
| Name | |
| Address | |
|  | Postcode |
| Daytime | Evening |
| Date of anti-tetanus | NHS Number. |

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| **(4) Dietary Requirements** | |
| Do you / does your child have any dietary, faith or cultural needs e.g. vegetarian, vegan? | |
|  | \* If YES, please give details. Please list recommended brands, as well as specifying whether **‘may contain’** or similar qualifiers are appropriate. |
|  | |
| Continued in section 10 | |

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| **(5) Allergies** | |
| Are you / is your child allergic to anything? (Antibiotics, any particular food, first aid supplies or medication etc). | |
|  | \* If YES, please give details |
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| Continued in section 10 | |

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| **(6) Medical Conditions** | |
| Do you / does your child suffer from asthma, chest complaint, wheezing or hay fever, migraine, fits or faints, bad period pains, diabetes, nervous disorders, any other illness or disability? | |
|  | \* If YES, please give details |
|  | |
| Continued in section 10 | |

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| **(7) Recent Infectious Diseases** | |
| Have you / has your child had contact with any infectious illnesses (including COVID-19) within the last month? | |
|  | \* If YES, please give details |
|  | |
| If you / your child is showing signs or symptoms or are testing positive for COVID-19, we ask that you do not attend the event. | |
| Continued in section 10 | |

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| **(8) First Aid Provision** | | | |
| The following first aid equipment may be available if required. If you are / your child is allergic to any items below, please suggest a suitable alternative below. Please mark any which cannot be used. | | | |
| Antiseptic wipes |  | Triangular bandages |  |
| Micropore tape |  | Sterile gloves |  |
| Sterile Gauze |  | Tubigrip |  |
| Sterile Eye Patch |  | Sterile water sachets |  |
| Fabric plasters |  | Sun cream (SPF 30) |  |
| Non-fabric plasters |  | After-sun cream |  |
| Steristrips |  | Anthisan Cream |  |
| Open weave bandages |  | Non-adherent sterile dressings |  |
| Crepe bandages |  | Instant Ice Packs |  |
| Alternatives: |  | | |
| All of the above can be used for my child / myself | | | |
| Continued in section 10 | | | |

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| **(9) Standard Medications** | | |
| The following standard pain-relieving medications may be available if required. Please indicate whether each can be used. | | |
| Calpol (6+) | Paracetamol Liquid |  |
| Calprofen (3 month+) | Ibuprofen Liquid |  |
| Generic Pharmaceutical Brand | Paracetamol Tablets |  |

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| **(10) Medication** | | | | |
| Are you / is your child taking any medications at present? | | | | |
|  | | \* If YES, please complete full dosage and timing information below | | |
| MEDICATION REQUIRED SHOULD BE GIVEN TO THE SCOUTER-IN-CHARGE OR THE FIRST AIDER, CLEARLY MARKED WITH NAME AND FULL INSTRUCTIONS FOR USE. | | | | |
| **Regular Repeated Medication** | | | | |
| **Medication** | **Purpose** | | **Frequency** | **Dosage** |
|  |  | |  |  |
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|  |  | |  |  |
|  |  | |  |  |
| **Ad. Hoc or As-Necessary Medication** | | | | |
| **Medication** | **Purpose** | | **When required** | **Dosage** |
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| **(11) Any Additional Information** |
| Please specify any additional information you feel the event leader may benefit from knowing. |
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| **(12) Appendix Attached** | |
| I have included an appendix with further details |  |

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| **(13) Authorisation** | | |
| By signing below, I give permission for my child or myself to attend the listed event and for qualified leaders to **administer any first aid** as required and receive medication as instructed above and any emergency dental, medical or surgical treatment, including anaesthetic, as considered necessary by medical authorities present. | | |
| Members of the Scout Association aged 18 or over may sign the form themselves: for children under 18 this must be the parent or guardian. | | |
| If any of the above statements change in any way prior to the event, please ensure that you update the event leader. | | |
| Signed | Date | Event |
| \* | The information given is correct | |