



### Medical Information (Adult)

Name	Date of Birth	M	F
		Sex	
Phone			
Email Address	Next of Kin		
Address			

### Emergency Contacts

Primary Emergency Contact		Secondary Emergency Contact	
Mobile Phone	Second contact number	Mobile Phone	Second contact number
Address		Address	

### Medical Information

Allergies/Special Health Considerations, e.g. asthma, sight/hearing difficulties, heart condition, diabetes, epilepsy, allergies (pollen, nuts, medicines, etc.), adverse reactions to bee or wasp stings

Dietary requirements

I hereby grant permission for emergency medical treatment or medication to be administered to me by on-site first aiders or qualified medical respondents in the event of an accident:

Signature

Date