THE GIRL GUIDES ASSOCIATION OF TRINIDAD AND TOBAGO

PERSONAL HEALTH FORM

NAME _____ DATE OF BIRTH _____
First Family

ADDRESS _____ BLOOD TYPE _____
_____ HEIGHT _____
WEIGHT

NEXT OF KIN
NAME _____ CONTACT TELEPHONE
Home _____Work_____

Email _____

ADDRESS (If different from above) _____

Date of last physical exam: _____ Do you carry medical insurance? YES NO

If YES, indicate: _____

Under the care of a physician for the following conditions: _____

_____

Current treatment (including current medication): _____

_____

Specify dosages: _____

_____

Do you have any special instructions for your health care and/or diet? Are there any activities encouraged or limited by physician?

_____

_____

_____

Do you have any allergies to such things as drugs, food, plants, insect bites, etc? If so, please list allergies, giving the type of reaction and treatment.

_____

_____

_____

Please circle any of the following that you suffer from:

Arthritis	Headaches	Motion Sickness	Convulsions
Constipation	Ear Trouble	Fainting	Diabetes
Asthma	Epilepsy	Anaemia	Nose Bleeds
Sickle Cell	Menstrual Cramps	Heart Defect	Hypertension
Glandular Fever	Respiratory Ailments		

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What was the date of your last tetanus shot? _____

Have you ever had the following? (give approximate dates)

Chicken pox _____ Measles _____

Mumps _____ German measles _____

Please give details of usual treatment, should conditions (from above) occur:

_____

_____

_____

Chronic conditions or recent illnesses of which the staff should be aware of:

_____

_____

Please specify details of medication or treatment required for the above:

_____

_____

_____

Please list any other medication that you are bringing:

_____

_____

This health history of _____(name of participant) is correct so far as I know, and this person described has permission to engage in all prescribed activities except as noted.

Authorisation for Treatment

I hereby give permission to the medical personnel selected by ***the Camp Commandant*** To order X-rays, routine tests, treatment and necessary transportation for the person mentioned. In the event I cannot be reached I hereby give permission to a physician selected by ***the Camp Commandant*** to secure and administer treatment including hospitalization, for the person mentioned above. I also release the Girl Guides Association of Trinidad and Tobago of any responsibility of accident or injury occurred during **CAMP – Opening Wide Leadership – O.W.L.** from **30th May – 3rd June, 2018**
(events, dates)

DATE _____ SIGNATURE _____
(day/month/year)

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FORM OF INDEMINITY

I authorize the Commandant of the Girl Guide Camp to be held at **CAMP – Opening Wide Leadership – O.W.L.** from **30th May – 3rd June, 2018** to obtain for myself (name in caps) _____ all such medical assistance as such Commandant should consider necessary.

The Doctor with whom she should communicate is: _____

Address _____

Telephone _____ Email_____

Emergency Contact _____

Address _____

Telephone _____ Email_____

If it should prove impractical to contact the Doctor named, or Emergency Contact, and the Commandant considers it necessary to take other steps, she is authorized to do so.

I agree to pay all expenses incurred on my behalf of the said ***Camp Commandant*** such fees to be paid to the Secretary, Girl Guides Association of Trinidad and Tobago on demand.

DATE _____ SIGNATURE _____

(day/month/year)