

# Confidential Medical Questionnaire/ Consent Form



## EJO INTERNATIONAL SUMMER PROGRAMMES

Please make sure your son/daughter brings this form to England, completed and signed by you. It is **ESSENTIAL** for us to have this information in case of emergency.

Centre / Course code:

Arrival date:

Departure date:

Name of student:

Group:

Date of Birth:

Tick if 18 or over

Name & address of person who should be contacted in an emergency:

Contact telephone number:

Email:

Is the student covered by medical insurance? YES  NO

Does he/she have any of the following? E128  E112  European Health Insurance Card  Other

Does the student suffer from any of the following? If YES, please give details below:

|                           |                              |                             |                                   |                              |                             |
|---------------------------|------------------------------|-----------------------------|-----------------------------------|------------------------------|-----------------------------|
| Asthma/bronchitis         | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Fits, fainting, blackouts         | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Allergies to medication   | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Other allergies e.g food, animals | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Heart condition           | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Diabetes                          | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Migraine/severe headaches | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Travel sickness                   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Other illness/disability  | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Regular medication                | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

DETAILS:

If it is considered necessary, do you consent to mild pain killers (e.g Paracetamol) being administered? YES  NO

Has the student been vaccinated against tetanus in the last 10 years? YES  NO

Has the student had surgery/specific medical treatment of any kind recently? (If the answer is YES, please give details overleaf) YES  NO

I confirm that I am the parent/guardian of the above-named student. He/she is in good health and I consent to him/her taking part in the activities of the centre. In the event of illness or accident, I consent to any necessary medical treatment, including the use of anaesthetics.

Signed:

Relationship to student:

Date: