

Medical Questionnaire

Completion is optional.

If you have a medical condition or are on medication that you would like us to know about in case of an emergency, please complete this form, place it in a sealed envelope with your name and course number on the front and hand it in at reception on arrival.

This form will be treated as confidential and only read in an emergency. If you wish it can be collected on departure, otherwise it will be destroyed. Please complete all sections and print clearly.

| | |
|----------------|-----------------|
| Name: | Date of Birth: |
| Address: | |
| Course Number: | Date of Course: |
| Course Title: | |

In case of an emergency, please provide contact details of a relative or close friend:

| | |
|----------|-------------------|
| Name: | Telephone Number: |
| Address: | |

Please provide details of your doctor's surgery:

| | |
|-----------------|-------------------|
| Name of Doctor: | Telephone Number: |
| Address: | |

Please tick if you suffer from any of the following and give further explanation below:

- | | | | |
|-------------------------|--------------------------|------------------------|--------------------------|
| Diabetes | <input type="checkbox"/> | Gastric/Duodenal Ulcer | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> |
| Heart Related Condition | <input type="checkbox"/> | Blackouts/Fainting | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | | |

Allergies (Please state what allergies you have):

Please state any prescribed medication and the dosage which you take regularly:

The information provided will help us to cope with any emergency which may occur whilst you are at Denman. We have had incidents which highlighted the importance of this information, so please help us to help you. Thank you for your co-operation.