The Christian Adventure Centre
The Old Vicarage
Viney Hill
Lydney
Gloucestershire
GL15 4NA

Tel: (01594) 516162
Email: info@vineyhilladventure.org
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Medical Form

Please complete both sides of this form and hand it to the person in charge of your group. If you are under 18 this form must be completed by a parent or guardian. We require a completed form for every member of the group, including leaders.

Group leaders, please be advised that this information is for VH staff use only. If you wish to have the forms available for your own use while you are with us, for instance to cover any night time emergencies, please make additional copies to keep with you.

When you share your personal data with us, we treat it with care and take our responsibility to protect it seriously. We store medical forms in a secure location and retain your forms for 6 months from the date of your visit. After this time any confidential information is destroyed unless there has been an accident during our activities, in which case we would keep the information with the accident form for 5 years in case of litigation.

I have read and understood this information: Yes/No

Name of School/ Church etc ..... **Date of visit** .....

Details of Participant

Last Name	First Name	Date of Birth	Male/Female	Nationality	Occupation
Address					
Post Code					
Telephone No *Home*		*Work*		*Mobile*	

Important Contacts

	Name	Address	Tel
Person to contact in an emergency			*Home* *Work* *Mobile*
Your Doctor			

Any illness or condition that may affect you during an activity *must* be declared. If not, The Christian Adventure Centre cannot be held responsible for any accident occurring as a result of that condition. If there are any changes to the information given below, please inform The Christian Adventure Centre immediately.

If you have a medical condition that requires the use of 'sharps' please make your own arrangements for safe disposal as we do not have disposal facilities at the Centre.

Photographs may be taken of young people whilst on activities. These may be used in publicity or on our website, but no child or group will be identified. If you do not wish to give permission for this, please tick box. ☐

Medical Details

Participant's name ..... **Date of visit** .....

Information provided on this form will be treated as CONFIDENTIAL.

	Have you ever had?	**Yes/No**	**If 'yes' please give details, including dates.**
1	Heart trouble, raised blood pressure?		
2	Asthma, bronchitis, tuberculosis?		
3	Diabetes?		
4	Epilepsy, fainting attacks, migraine, severe head injury?		
5	Nervous illness or psychiatric treatment?		
6	Hayfever or other allergy?		
7	Allergy to insect bites, especially wasps?		
8	History of fractures or tendon/ligament damage (e.g. back, neck, arms, ankles or knees)?		
9	A tetanus injection? If so, state date of most recent.		
10	Are you suffering from, or are you a carrier of any infectious diseases?		
11	Have you been treated by a doctor or been in hospital within the last 2 years?		
12	Are you taking any medication? If so, please give details, state dosage and ensure you bring enough.		
13	Have you any special dietary requirements (e.g. vegetarian or vegan); or food allergies (e.g. to nuts)?		
14	Do you have, or suffer from any other medical or physical condition?		

In signing for a participant who is under 18 years of age, you endorse the following:

"I wish the above-named participant to be allowed to take part in the above course and consent to him/her taking part in all activities. I have ensured his/her willingness to participate in all aspects of the course. In the event of an emergency and the Centre being unable to contact me, I give permission for any medical treatment deemed necessary to ensure the well-being of the above-named to take place".

Signature ..... Print name ..... Date .....

Relationship to child (if applicable) .....