Endurance2020 – Health Form: Part 1

Please write clearly and complete all sections on both parts of the health form.
Information detailed on this document will be held in accordance with Endurance80 Data Privacy Policy, with access only being granted to authorised staff.

Team Name:

Team Leader Name:

Full Name: **Age at start of Event (if <18):**

Date of Birth: **National Health Number:**

When was your last Tetanus injection? Date:

Emergency Permission –
I give permission for a first aider to give treatment for any illness or injury during Endurance2020. I also give permission for any First Aider/Authorised Leader to give consent for the necessary Hospital Medical treatment provided reasonable attempts have been made to contact the next of kin.

Full name:

Signed: **Date:**

Relationship*:

This must be signed by the parent or guardian if the participant is under 16 years of age at the start of Endurance2020 or by the participant if over 16 years old.

Doctor's Name:

Address:

Telephone:

Next of kin: **Relationship:**

Address:

Day phone: **Evening phone:** **Mobile phone:**

Part 2 overleaf

Endurance2020 – Health Form: Part 2

Medical History –
Do you have medical conditions such as the following?

Diabetes: ☐ Epilepsy: ☐ Asthma: ☐ Heart Conditions: ☐ Penicillin Allergy: ☐

Other Condition or Allergy:

Details of any prescribed medication/treatments currently being taken/followed (including dosage details) and the specialist and Hospital concerned if appropriate (please include any non-prescription preparations such as herbal medicines):

Generic or Brand	***Name Dosage Details***

Please indicate below any medical history that we should know about, particularly any current treatment or any investigations in the last 6 months, or any surgery that has been carried out.

Medication Available on site –
The following may be available from the first aid team, please indicate which can and cannot be used. Dosages will be in accordance with the manufacturers/suppliers recommended dose.

Medication	Yes	No	Medication	Yes	No
Paracetamol			Ibuprofen		
Chlorphiramine (piriton)			Plasters		

I give permission for the above to be used as indicated

Full name:

Signed: **Date:**

Mobile number of walker when on the walk (if carried)

☐ ***By ticking this box and submitting this form you confirm the information contained is correct.***

Official use only – *walker number*