



Medical and Consent Form

This form is to be completed by a PARENT or GUARDIAN in BLOCK CAPITALS. All information will be held on file by Habonim Dror, but will remain CONFIDENTIAL.

Forename:	Date of Birth:
Surname:	Name of Camp:

CONDITIONS

- | | | | | | | | |
|-------------|--------------------------|-----------------|--------------------------|-----------------|--------------------------|-----------------------------------|--------------------------|
| Anorexia | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | German Measles | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Ear Infections | <input type="checkbox"/> | Glandular Fever | <input type="checkbox"/> | Polio | <input type="checkbox"/> |
| Bed Wetting | <input type="checkbox"/> | Eczema | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | Scarlet Fever | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | Hyperactivity | <input type="checkbox"/> | Skin Conditions | <input type="checkbox"/> |
| Bulimia | <input type="checkbox"/> | Eye Problems | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> | Sleepwalking | <input type="checkbox"/> |
| Chicken Pox | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | Measles | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Freq. headaches | <input type="checkbox"/> | Mumps | <input type="checkbox"/> | Other (please give details below) | <input type="checkbox"/> |

PSYCHOLOGICAL/EMOTIONAL PROBLEMS

Please tick if the participant suffers from ANY psychological or emotional problems and give FULL details below, including a doctors letter where appropriate.

ALLERGIES

Please tick if the participant is allergic to any of the following, and give details where appropriate:

- | | | | | | |
|---------|--------------------------|---------------------|--------------------------|-------------|--------------------------|
| Aspirin | <input type="checkbox"/> | Fruit | <input type="checkbox"/> | Paracetamol | <input type="checkbox"/> |
| Dairy | <input type="checkbox"/> | Gluten | <input type="checkbox"/> | Plasters | <input type="checkbox"/> |
| Eggs | <input type="checkbox"/> | Insect Stings/Bites | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> |
| Fish | <input type="checkbox"/> | Nuts | <input type="checkbox"/> | Pets/Horses | <input type="checkbox"/> |

Other Allergies:

Details of Allergies:

MEDICATION

Please give FULL details of any current medication or medical treatment:

Please tick this box if you DO NOT wish the participant to be administered with paracetamol: