



Correspondance to:  
BCM Ireland  
Castledaly Manor,  
Athlone,  
Co. Westmeath

## Camper Medical Form

This form is to be completed and signed by your parent/guardian and brought to camp.

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Does your child suffer from?**

Yes No

- Migraine / Headaches
- Fainting
- Asthma
- Hay Fever
- Diabetes
- Heart condition
- Epilepsy
- Autism
- Other (Please specify)

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We at BCM want to ensure your child is catered for and thoroughly enjoys his/her stay. **Please let us know** of any particular requirement they may have so we can help this happen

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies?**

Yes No

- Food
- Medicine
- Stings
- Dust
- Other (Please specify)

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If **Yes**, please give details. (Please include reactions)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medicine & Instructions** (Please leave all medicines in original packets/containers.)

*Name & Strength:* Please give the reason for the medicine and how often the camper needs it

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**General**

Date of last tetanus injection: \_\_\_\_\_ (if unknown, is it within the last ten years? Your GP or local health board will know)

Has your child been in contact with any infectious diseases within the last three weeks? Yes \_\_\_ No \_\_\_

If yes, please give details: \_\_\_\_\_

Doctors Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Home contact Name: \_\_\_\_\_ Phone No. \_\_\_\_\_

Backup Name and phone number and relationship to camper.

\_\_\_\_\_

**Consent:**

I understand that in the event on an emergency if it is not possible to contact me or other nominated persons, I authorise the leader in charge to give consent, on my behalf for any medical treatment as may be necessary for my child while in the care of BCM Ireland.

Signature of Parent / Legal Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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