



Correspondence to:
BCM Ireland
Castledaly Manor,
Moate,
Athlone,
Co. Westmeath

Staff Medical Form

This form is to be completed and brought to camp.

Name _____ Date of Birth ____/____/____

Does you suffer from?

Yes No

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

___ ___
 ___ ___
 ___ ___
 ___ ___
 ___ ___
 ___ ___
 ___ ___
 ___ ___

If **Yes**, please give details.

Allergies?

Yes No

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

___ ___
 ___ ___
 ___ ___
 ___ ___
 ___ ___

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 you need it

General

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

Have you been in contact with any infectious diseases within the last three weeks? Yes ___ No ___

Doctors Name _____ Phone No. _____

Home contact Name: _____ Phone No. _____

Backup Name and phone number and relationship to you.

Consent: (if under 18)

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 ____/____/____

Signature of Leader _____ Date ____/____/____