Medical Questionnaire

Participant Name .... Age..........

Address..
...
.. Post Code ....

Email Address ....

Telephone ....

The following list is not exhaustive, add additional issues in the box below:

Question	Yes	No
Do you have asthma, bronchitis, a heart condition, diabetes, severe headaches, travel sickness, fits, fainting or blackouts?	☐	☐
Do you have an allergy to known medication, pollen, materials, food, plasters or other items?	☐	☐
Do you have a disability, learning condition or medical condition which may affect your participation or learning?	☐	☐
Have you been vaccinated against tetanus in the last ten years?	☐	☐
Are you receiving medical or surgical treatment of any kind from either your family doctor or hospital or been given specific medical advice to follow in an emergency?	☐	☐
	☐	☐

If you have answered yes to any of the above questions please give details below:

I confirm that I have read, understood, and agree to abide by the Terms and Conditions and that I have filled out the Medical Declaration section on this form.

If under the age of 18 this section must be signed by a parent or legal guardian.

Signed .... Date..

Print ....