

1ST WELWYN GARDEN CITY (ST FRANCIS) SCOUT GROUP
PERMISSION TO CAMP / SCOUT REGISTRATION FORM

NAME:		PACK/TROOP:	
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ADDRESS:			
POST CODE:		TELEPHONE NO:	

DATE OF BIRTH:		AGE:	
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GP NAME:		GP TELEPHONE:	
GP ADDRESS:			
NHS NUMBER:		PLACE OF BIRTH:	

NEXT OF KIN:		TELEPHONE NO:	
RELATIONSHIP:			

NEXT OF KIN:		TELEPHONE NO:	
RELATIONSHIP:			

DRUG ALLERGIES:	
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MEDICATION:		
DRUG	DOSE	WHEN REQUIRED

MEDICAL HISTORY:	
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FOOD PREFERENCES:	
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MY SON/DAUGHTER IS A VEGETERIAN

I GIVE MY SON/DAUGHTER PERMISSION TO:

SHOOT RIFLES ARCHERY SWIM (MY SON/DAUGHTER CAN SWIM > 10M)

I GIVE THE GROUP FIRST AIDER PERMISSION TO ADMINISTER THE FOLLOWING MEDICATION TO MY SON/DAUGHTER IF REQUIRED:

CALPOL CALPROFEN PARACETAMOL IBUPROFEN

IMODIUM REHYDRATING SALTS

SIGNED _____ PRINT NAME _____