# St. Julian's Scout Group

## Health Form

CONFIDENTIAL

<table>
<tr><td colspan="4">Name of Member:</td><td colspan="2">DOB:</td></tr>
<tr><td>Blood Group:</td><td colspan="2">Mother's Name:</td><td colspan="3">Father's Name:</td></tr>
<tr><td colspan="6">Home No. / Name:</td></tr>
<tr><td colspan="6">Street:</td></tr>
<tr><td colspan="4">Locality</td><td colspan="2">Post Code:</td></tr>
<tr><td colspan="2">Home Tel.No.</td><td colspan="2">Work Tel. No.</td><td colspan="2">Mobile:</td></tr>
<tr><td colspan="3">Next of Kin Name:</td><td colspan="2">Tel.:</td><td>Mobile:</td></tr>
<tr><td colspan="3">Family Doctor Name:</td><td colspan="2">Tel:</td><td>Mobile:</td></tr>
<tr><th colspan="3">Suffers From</th><th colspan="3">Allergies</th></tr>
<tr><td colspan="3">Asthma ☐ Epilepsy ☐ Diabetic ☐</td><td colspan="3">Penicillin ☐ Antiseptics ☐ Zinc Oxide ☐</td></tr>
<tr><td colspan="3">Heart Defects ☐ Sleep Walking ☐</td><td colspan="3">Nuts ☐ Bee Stings ☐</td></tr>
<tr><td colspan="3">Any other illness : Yes ☐ No ☐</td><td colspan="3">Any other Allergies: Yes ☐ No ☐</td></tr>
<tr><td colspan="3">If Yes state which</td><td colspan="3">If Yes state which:</td></tr>
<tr><td colspan="6">Is your child under any type of medical treatment / medicine Yes ☐ No ☐</td></tr>
<tr><td colspan="6">If Yes state name of medicine, dose, and times of administration.</td></tr>
<tr><td colspan="6"></td></tr>
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