LEARNING Outdoors Team

Hampshire County Council
Outdoor Centres

# Staff Medical and NOK Form

| **Personal Details** | | | | | |
|---|---|---|---|---|---|
| First Name: | | Surname: | | Mobile: | |
| Date of Birth: | ___ /___ /___ | Age: | Male / Female / Other (delete as appropriate) | | |
| Address: | | | | Post Code: | |
| Next of Kin – name and address during the activity (if different from above) | | | | | |
| Contact Numbers: | Home: | | Work: | | Mobile: |
| Any special dietary requirements: | | | | | |

**Medical Information**

Name and address of doctor:

| Telephone Number: | NHS Number (if known): |
|---|---|

**Have you had or have any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| Asthma or bronchitis | Yes | No | Allergies to any know medication | Yes | No |
| Heart condition | Yes | No | Other allergies (material, food, animal, plasters) | Yes | No |
| Fits, fainting or blackouts | Yes | No | Other illness, disability or special needs | Yes | No |
| Severe headaches | Yes | No | Travel sickness or sleepwalking | Yes | No |
| Diabetes | Yes | No | Regular medication | Yes | No |

**Are you receiving -**

| | | |
|---|---|---|
| Support and/or treatment for mental health from a counsellor or doctor? | Yes | No |
| Medical or surgical treatment of any kind from a doctor or hospital? | Yes | No |
| Have you been given specific medical advice to follow in emergencies? | Yes | No |

***If the answer to any of these questions is Yes, please give details below (including name and dosage of any medicines/tablets)***

**Have you received vaccination against Tetanus in the last 10 years?** Yes No

**Any Additional Medical or Special Needs Information**

| Signature: | Date: |
|---|---|

**Print name here:**