



WCF Child Protection Medical Information

WCFCP Form 2
Effective Date 21.10.08
Version 2

Young Person details

Name of young person _____

Date of birth: _____

Address _____

Post or Zip Code _____

Nationality: _____

Mobile or cell phone number: _____

Passport or Identification Card Number: _____

Medical information

1. Does the young person have any specific medical conditions requiring medical treatment and/or medication?

Yes / No (delete as appropriate)

If Yes: give details: _____

2. Does the young person have any allergies?

Yes / No (delete as appropriate)

If Yes: give details: _____



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3. Has the young person had any contact with contagious or infectious diseases within the last four weeks?

Yes / No (delete as appropriate)

If Yes: give details: _____

4. Does the young person take any medication for asthma?

Yes / No (delete as appropriate)

If Yes: give details: _____

5. Please provide details of any special dietary requirements and the type of pain/flu medication that may be given.

6. Any other relevant information

7. I confirm that the young person can swim and I consent to them being allowed to do so.

Yes / No (delete as appropriate)

Signature

_____ (consent by parent/guardian)

Date: _____

_____ (signature of young person)