Stockland Lovell Summer Camp
Fri 14th – Sun 16th June 2024
Medical Form

FIRST NAME: .....**Mr/Mrs/Miss**
SURNAME: .....
ADDRESS: .....
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Postcode:
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Tel Home:
…….…..……..…..…….....
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Work:
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Mobile:
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Email:
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…..……..
Date of birth:
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NEXT OF KIN
NAME:
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Tel Home :
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Work : .....
Mobile:
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GP DETAILS
Name of Doctor:
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…….
Practice Address:
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……
Postcode:
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Tel. No:
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Do you have any dietary requirements: **YES □ NO □**

If yes, please detail:

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Do you have any ongoing injuries or health problems: **YES □ NO □**

If yes please detail:

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Do you have any allergies: **YES □ NO □**

If yes please detail:

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Have you suffered any injuries in the past: **YES □ NO □**

If yes, please detail:

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Signature: …….. **Date**:
…….

The information on this form will be destroyed 3 months after the date of the camp and will not be stored or shared by/with any other party other than Stockland Lovell for the duration of the camp weekend. In an emergency you information may also be shared with a medical professional.