



Stockland Lovell Summer Camp
Fri 3rd – Sun 5th June 2022
Medical Form

FIRST NAME: **Mr/Mrs/Miss**
SURNAME:
ADDRESS:
.....
.....
Postcode:
Tel Home:
Work:
Mobile:
Email:
Date of birth:

NEXT OF KIN

NAME:
Tel Home :
Work :
Mobile:

GP DETAILS

Name of Doctor:
Practice Address:
.....
.....
Postcode:
Tel. No:

Do you have any dietary requirements: YES NO
If yes, please detail:

Do you have any ongoing injuries or health problems: YES NO
If yes please detail:

Do you have any allergies: YES NO
If yes please detail:

Have you suffered any injuries in the past: YES NO
If yes, please detail:

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.