بسم الله الرحمن الرحيم

SCOUTS Maldives

The Scout Association of Maldives

HEALTH FORM

1. Personal Data:

Name:			Sex: M		F:
Date of Birth:		(dd/mm/yyyy)	Age:		
Present Address:					
Mobile:		Tel:		Fax	
Email:			Blood Group		

2. Contact Person 1 (in case of emergency)

Full Name:			Relationship:		
Mobile:		Tel:		Fax:	

3. Contact Person 2 (in case of emergency)

Full Name:			Relationship:		
Mobile:		Tel:		Fax:	

CONSENT

I understand that the participation in scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I have carefully considered the risk involved and have given consent for myself or my child to participate in this activity. I also understand that participation in this activity is entirely voluntary and requires participants to abide by applicable rules and regulations and standards of conduct. I release The Scout Association of Maldives, the Local Council, the activity coordinators, and all professional staff, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

In case of emergency involving my self/child, I understand that every effort will be made to contact my contact person. I hereby give my permission to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

Name: _____ Sign: _____ Date: _____

For use of The Scout Association of Maldives

Received by:_____ Date:_____ Time: _____

Remarks:_____

Have or subject to (check if yes)

☐ Fainting Spells	☐ Palpitation	☐ Abdominal Pain	☐ Nervousness	☐ Shortness of Breath
☐ Headache	☐ Convulsions	☐ Frequent Cough	☐ Easy Fatigue	☐ Frequent Fever
☐ Chest Pain	☐ Asthma	☐ Others: ______________		

Have or subject to trouble with (check if yes):

☐ Eye, Ear, Nose, Throat	☐ Hernia	☐ Allergy
☐ Recurrent Diarrhea	☐ Heart	☐ Lungs
☐ Hypertension	☐ Kidney	☐ Enuresis (bed wetting)
☐ Diabetes	☐ Whooping Cough	☐ Sleep walking

Are you currently under any regular medication? ______________________________

Any restriction of activity for medical reasons? ______________________________

Explain ____

<u>If applicant is under 18 years of age</u>: In the event of illness or injury occurring to my son/daughter during his/her attendance at the event, I hereby consent to advance to whatever medical or surgical diagnostic procedure or treatment is considered necessary in the best judgement of the attending physician and performed by or under the supervision of a member of the medical staff furnishing medical services. I understand that, in the event of a serious illness or injury, reasonable efforts to reach me will be attempted.

I certify and confirm that the intervention provided above is fine and correct.

Signed: ____________________ Date: __________________ Approved by: ________________________

Applicant Parent or Guardian

I/ we certify that the information given on this form is true and correct

Parent/ Guardian: Signature: Date:

Participant: Signature: Date:

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