MEDICAL FORM

Offshore Safety

Name: …….

Date of birth: ……

Next of kin: ……..... **Relationship:** ……

Home: …… **Work:** ……...**Mobile:** …..…….……

Doctor: ……..…… **Practice:** ……..……

It is your responsibility to make known any potential medical conditions that may affect you during the activities associated with the programme you will be taking part in. Please therefore provide as many details as possible.

Have you ever suffered from any of the following conditions: -

• Asthma/bronchitis	Yes	No
• Heart conditions	Yes	No
• Fits, fainting or blackouts	Yes	No
• Severe headaches	Yes	No
• Diabetes	Yes	No
• Travel sickness	Yes	No
• Allergies to medication	Yes	No
• Any other allergies	Yes	No
• Other illnesses or disabilities	Yes	No

If you have answered yes to any of the above, please provide details in the box below.

Are you currently taking any medication at the moment? If so please specify.

Are you suffering/recovering from any injuries which may affect your involvement?

Are you vegetarian? Do you have any food or other allergies?

Signed: ……Name: …… Date: ……..……