MEDICAL CONSENT FORM

Patient Details	
Surname:	Forename:
Address:	
Doctor name:	
Doctor's address:	
Doctor's contact number:	

Medical Information

1. Do you have any dietary requirements / food allergies? *If YES, give additional information.* ☐ Yes ☐ No

2. Do you have any medical conditions requiring medical treatment, please include allergies and medication? *If YES, please state.* ☐ Yes ☐ No

3. Do you have health insurance (for travel abroad)? *If YES, please state (i.e. EHIC / Private insurance)* ☐ Yes ☐ No