



WHITGIFT SCHOOL HOCKEY CAMP
Confidential Medical + Information Questionnaire

To be completed by parent in BLOCK LETTERS and returned to Mr Davenport at your earliest convenience

First Names:

Surname:

Date of birth:

Position: GOALKEEPER / DEFENDER / MIDFIELDER / FORWARD / UNSURE

Hockey Experience: BEGINNER / INTERMEDIATE / ADVANCED

Attending Camp: JULY / AUGUST

Emergency Contact Name:

Emergency Contact Tel No (Home + Mobile):

Home Address:

- 1) Does your son suffer from any serious medical condition? (e.g. diabetes, epilepsy)

- 2) Does your son suffer from any allergies? (e.g. asthma, eczema, hay fever)

- 3) Does your son require any regular medication? Please give details, and bring any medication he may need during the camp.

- 4) Does your son have any known sensitivity to drugs? (e.g. penicillin, aspirin)

5) Does your son wear spectacles or contact lenses?

6) Name, address and telephone no. of Family Doctor

7) Please list any additional information you feel would be important for us to know.

8) Do you consent to your son having his photograph taken for possible use in future promotional/marketing material?

Many thanks,

**Tim Davenport
Hockey Development Officer
Whitgift School
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