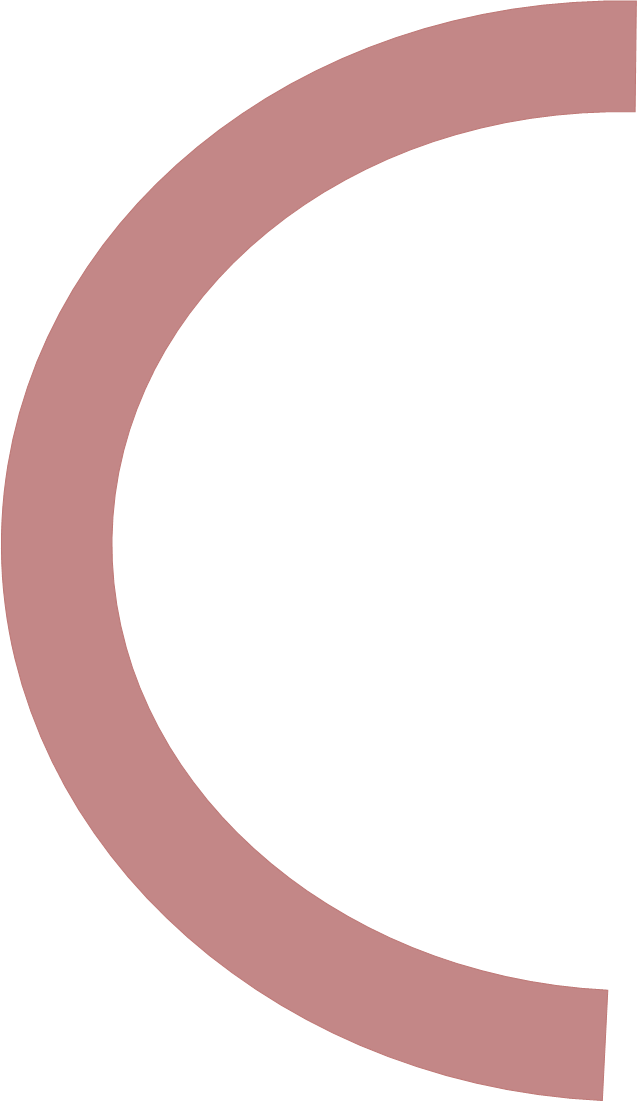
**Medical Form**

**Personal details**

|  |  |
| --- | --- |
| **Surname** |  |
| **First name** |  |
| **Date of Birth** |  |
| **Country** |  |

**In case of emergency**

|  |  |
| --- | --- |
| **Person to contact** |  |
| **Mobile number\*** |  |
| **Address** |  |

*\*Please indicate country dialing code.*

**Medical requirements**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes or No** | **To what?** | **Medical treatment** |
| **Food allergies** |  |  |  |
| **Drug allergies** |  |  |  |
| **Other health problems** |  |  |  |

**Insurance**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of company** |  | **Number** |  |

**Date and signature\***

*\*Under -18’s must have form signed by their legal representative or guardian.*