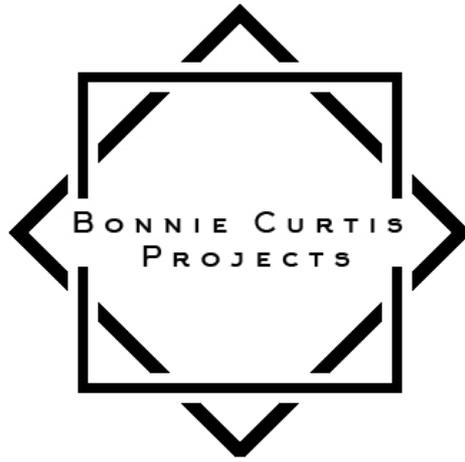


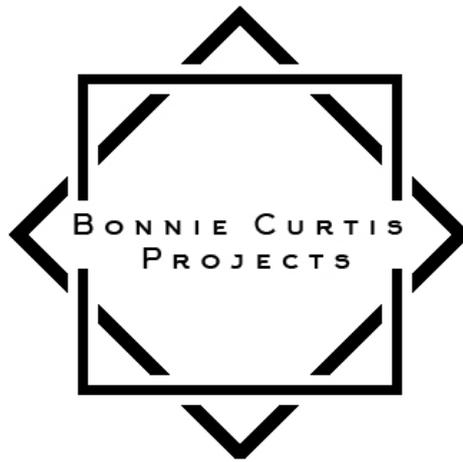
## Information Form

<p style="text-align: center;"><b>Section A</b> <b>Personal Details</b></p>
First Name:
Last Name:
Address:
Mobile No:
Email:



## Information Form

<p style="text-align: center;"><b>Section B</b> <b>Emergency Contact Details</b></p>
Name:
Relationship to you:
Address:
Mobile No:



## Information Form

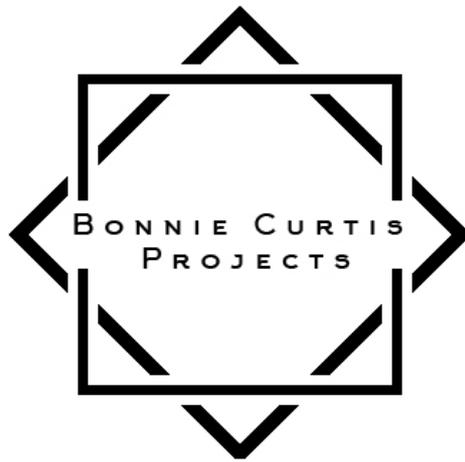
### Section C Medical Details

Please fill in this voluntary questionnaire and return it to Bonnie Curtis Projects. All information will be treated confidentially and cannot be used to discriminate against any person in any way. Access to, storage and archiving of this information shall be in accordance with all relevant legislative requirements. This information requested is designed to ensure that appropriate regard is given to the health and well-being of every person in the working environment.

Blood Type (if known):

Doctor Name (if relevant):

Doctor Phone No:



## Information Form

### Section C

#### Medical Details Continued

Do you have any physical disabilities or pre-existing medical conditions?

Yes  No

If yes, please provide details including treatment in the event of an incident (eg asthma, epilepsy, diabetes, back problems).

Do you have eyesight impairment that requires you to wear glasses?

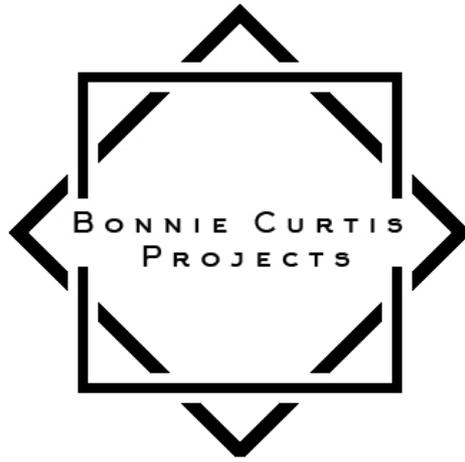
Yes  No

Do you have hearing impairment that requires you to utilise a hearing aid?

Yes  No

Have you had a tetanus injection in the last five years?

Yes  No



## Information Form

### Section C

#### Medical Details Continued

Do you have any allergies?

Yes  No

If yes, please detail any allergies to drugs, including drugs such as penicillin, antihistamines, aspirin etc

Are you on any regular medication at this time?

Yes  No

If yes, please provide details

Signed:

(Participant)

Date: