Information Form

Section A **Personal Details**	
First Name:	Last Name:
Address:	Mobile No:
	Email:
Section B **Emergency Contact Details**	
Name:	Relationship to you:
Address:	Mobile No:
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:
1. 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). 2. Do you have eyesight impairment that requires you to wear glasses? [ ] Yes [ ] No 3. Do you have hearing impairment that requires you to utilise a hearing aid? [ ] Yes [ ] No 4. Have you had a tetanus injection in the last five years? [ ] Yes [ ] No 5. Do you have any allergies? [ ] Yes [ ] No If yes, please detail any allergies to drugs, including drugs such as penicillin, antihistamines, aspirin etc 6. Are you on any regular medication at this time? [ ] Yes [ ] No If yes, please provide details	
Signed: (Participant)	Date: