

CONTACT DETAILS / MEDICAL FORM FOR GYMNASTS

Name of Gymnast:

Date of Birth: **British Gymnastics No (if applicable):**

Home Address:

..... **Post code:**

Details of Parent(s)/Guardian:

Name(s): **Relationship:**

Home Telephone: **Mobile(s):**

Email Address:

G.P's Name: **Tel:**

Does the Gymnast suffer from any of the following? (please delete)

Epilepsy	Yes/No	Asthma	Yes/No
Fever	Yes/No	Nose Bleeds	Yes/No
Allergies	Yes/No	Fits	Yes/No
Headaches/Migraine	Yes/No	Diabetes	Yes/No
Blood disorder	Yes/No	Deafness	Yes/No
Learning Difficulties	Yes/No	ADS	Yes/No

If you have answered yes to any of the above, please give details:

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Is the Gymnast on any on-going medication or on long-term treatment? Yes/No

If "yes" please give details:

Is the Gymnast allergic to: Plasters Yes/No Penicillin Yes/No
Insect Bites Yes/No Nuts Yes/No

Has the Gymnast ever had a broken limb or serious injury? Yes/No

If "yes" please give details:

Alternative Contact - Name: **Tel:**

**Is there any other information that we should have in the interests of the Gymnast?
(e.g. religion - will remain confidential)**

