

SOCIAL SCREENING QUESTIONNAIRE



The information you provide in this questionnaire will be used to assess whether you are at risk of injury and, in case of injury, to contact your next of kin. It is confidential and will not be shown to anyone except the team organiser.

1 PERSONAL DETAILS

Name: _____
First Last

Address: _____

Telephone: _____ Mobile: _____

Email: _____

Date of birth: ____/____/____
Day Month Year

Date this form was completed: ____/____/____
Day Month Year

2 NEXT OF KIN (EMERGENCY PURPOSES ONLY)

Name: _____

Address: _____

Telephone: _____ Mobile: _____

Relationship: _____

3 HEALTH HISTORY

Do you have any medical condition(s)/disability?
 If the answer is "yes", please list the condition and any medication you take for it.

Condition/disability <i>eg. asthma, heart disease, diabetes, epilepsy, HIV, anaemia, haemophilia, arthritis, viral illness, hepatitis A, B or C</i>	Medication <i>eg. tablets, inhalers, creams (give drug names)</i>	Frequency <i>eg. twice daily, only with symptoms</i>

Allergies <i>eg. bee stings</i>	Medication <i>eg. tablets, inhalers, creams (give drug names)</i>	Dose/frequency

