

Medical Health Questionnaire

Please PRINT CLEARLY answering the following questions carefully and accurately



TRIP DETAILS (to be completed by Leader-in-charge / Parent or Guardian)

Name of Scout / Guide Group or Unit _____

From _____ To _____

Destination(s) _____

Data Protection Act 1998 – I hereby consent to any information you may have about me / my child being processed by you for the purposes of providing insurance and claims handling, which may necessitate you providing such information to third parties.

Signature of Leader-in-charge / Parent or Guardian) _____ Date _____

Name _____

Address _____

Postcode _____

Date of birth _____ Height _____ Weight _____

MEDICAL HISTORY (to be completed by a qualified Medical Practitioner / Consultant)

The above named has applied for Travel Insurance and in order to consider the application we request the completion of this Questionnaire. All information will be treated in the strictest confidence and only used for the purpose of providing Insurance. PLEASE make sure each question is fully, legibly and accurately completed as answers that are difficult to read will only cause delay in processing this application.

Has the applicant ever suffered from high blood pressure, a stroke, a heart condition or other circulatory disorder? YES NO
If YES, please provide dates and full details including last three blood pressure readings and any treatment prescribed.

Has the applicant ever suffered from any cancerous or malignant condition? YES NO
If YES, please provide dates and full details including any treatment.

Has the applicant ever suffered from any mental, nervous, depressive or stress-related condition? YES NO
If YES, please provide dates and full details including cause(s), if known.

Has the applicant ever suffered from a 'slipped disc' or other spinal disorder, diabetes, a hernia, or any rheumatic or arthritic condition? YES NO
If YES, please provide dates and full details including any treatment.

MEDICAL HISTORY continued (To be completed by a qualified Medical Practitioner / Consultant)

In the past TWO years has the applicant suffered from any other injury, medical condition or defect which has not been covered by any of the questions above?

YES

NO

If YES, please provide dates and full details including treatment and prognosis.

To what degree are the condition(s) stabilised and controlled?

Is the applicant taking any medication?

YES

NO

If YES, please provide details below

Name of drug(s)	Dosage	Times taken per day
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Date of most recent medical check-up:

Dates and details of any future appointment(s) and/or treatment(s):

Have you discussed the planned trip with the applicant?

YES

NO

Do you consider the applicant to be at increased risk for the proposed trip?

YES

NO

And therefore fit to travel taking into consideration the medical condition(s) declared and the duration and destination(s) of the trip?

YES

NO

Please supply below any other information known to you which may be relevant to this application for insurance and which has not already been declared hereunder:

I am the Medical Practitioner / Consultant of the above-named applicant and in my opinion:

- This applicant is fit to make the proposed trip;
- Their health should not be adversely affected by the trip, taking into consideration the duration and destination(s) of the trip; and
- There is no medical reason at today's date why the trip should be cancelled between now and its commencement date.

Signature of

Medical Practitioner / Consultant

 Date

Please send to: **Unity Insurance Services**, Lancing Business Park, Lancing, West Sussex, BN15 8UG.

Tel: 0845 0945 702 Fax: 01903 751044