ACORN MEDICAL SERVICES

MEDICAL NEEDS ASSESSMENT

If not already done so, by providing your contact details, you give us permission to contact you by email

Your name:		**Organisation**	
Position:		**Address**	
Landline number:			
Mobile number:			
Event title:		**Postcode**	
Contact email address:			
Expected footfall per day:		**Captive?** ☐	**Floating?** ☐
Type of Event:			
Event location: (if not above)			
w3w location (if known)			

Event date/s	**COVER REQUIRED FROM:**	**COVER REQUIRED TO:**

If a reoccurring event, have there been any past medical issues?

Clear access for emergency vehicles?	**YES**	**NO**	**Is there a map of the event available?**	**YES**	**NO**
Are we to look after lost children?	**YES**	**NO**	**Do you have a Risk Assessment?**	**YES**	**NO**
Is alcohol being served?	**YES**	**NO**	**Will there be any attendees with SN?**	**YES**	**NO**
Any high- risk activities taking place?	**YES**	**NO**	**Are you in discussions with SAG?**	**YES**	**NO**
Event Location:	**INDOORS**	**OUTDOORS** **BOTH**	**Is our treatment centre required?**	**YES**	**NO**
Do you have a prepared Event Emergency Plan?	**YES**	**NO**	**Will there be food vendors on site?**	**YES**	**NO**
Is there any overnight camping?	**YES**	**NO**	**If so, are we to provide cover?**	**YES**	**NO**

Any other information you think we should be aware of?

For office use		
Client RA received	**YES**	**NO**
EMP to client	**YES**	**NO**
EMP to EMAS	**YES**	**NO**
Invoice to client	**YES**	**NO**
Deposit paid	**YES**	**NO**