MEDICAL INFORMATION FORM

Protecting your privacy is important to us. The information we seek allows us to manage risk, provide reasonable care and allow your involvement in our program. We are careful to keep your information confidential and provide it only to those agents acting on behalf of the organisation who require it to enable them to perform their agreed activities (e.g. First Aid Officer). We will not use your information for other purposes. In other circumstances, if you do not provide us with all the required information, your involvement in an activity could be prevented.

Program Applied for:					
Personal Contact Details:					
Participant's Full Name:					
Preferred Name (If applicable)		Gender:	❑ Male ❑ Female	D.O.B	
Address:					
Suburb:		Postcode:		Mobile/Phone:	
Is the participant under 18 years of age? ❑ Yes ❑ No					

Program Preparation	
Does the participant have any special dietary requirements? ❑ Yes ❑ No If Yes, please list them (We will endeavour to meet these requirements and will contact you if there are any problems.	
Can the participant swim?	❑ No ❑ Fair Swimmer ❑ Good Swimmer
Is the participant subject to sleepwalking?	❑ Yes ❑ No

Safety and Care Details		
In case of emergency, please list phone numbers where a friend or relative may be contacted during th course of this program.		
Name	Relationship	Phone Number
1.		
2.		

3. 4.		
5.		
Are there any health conditions which require special attention or care that we should know about? E.g. hearing or sight impairment, ADD or ADHD, behavioural issues, or any other? *Please list below:*		

Medical Information			
Medicare Number:		Position on Card:	
Please give details of the participants medical insurance *(if applicable)*			
Insurance Provider:			
Membership Number:			
If the applicant requires an EpiPen, they **MUST carry it with them at all times!*			
Has the participant recently been taken off any medications?	❑ Yes ❑ No	*If Yes, please provide details:*	
What is the year of the participants last tetanus injection?			
Has the participant previously fractured/broken any bones?	❑ Yes ❑ No	*If Yes, please provide details:*	

Specific Medical Conditions			
Please indicate in the relevant columns if the participant has had any of the following: *(Please provide details if necessary)*			
Condition	Present	In the past	Details
Sight/Hearing impairment	❑ Yes ❑ No	❑ Yes ❑ No	
Asthma	❑ Yes ❑ No	❑ Yes ❑ No	
Appendicitis	❑ Yes ❑ No	❑ Yes ❑ No	
Bronchitis	❑ Yes ❑ No	❑ Yes ❑ No	
Chicken Pox	❑ Yes ❑ No	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	❑ Yes ❑ No	
Ear Infections or other ear conditions (*e.g. Grommets*)	❑ Yes ❑ No	❑ Yes ❑ No	
Epilepsy	❑ Yes ❑ No	❑ Yes ❑ No	
Fits/Convulsions	❑ Yes ❑ No	❑ Yes ❑ No	

Faint/Dizziness	❑ Yes ❑ No	❑ Yes ❑ No	
Glandular Fever	❑ Yes ❑ No	❑ Yes ❑ No	
Hyperactivity	❑ Yes ❑ No	❑ Yes ❑ No	
Heart Conditions/Problems	❑ Yes ❑ No	❑ Yes ❑ No	
Measles or Mumps	❑ Yes ❑ No	❑ Yes ❑ No	
Pneumonia	❑ Yes ❑ No	❑ Yes ❑ No	
Tonsilitis	❑ Yes ❑ No	❑ Yes ❑ No	
Allergy- Food	❑ Yes ❑ No	❑ Yes ❑ No	
Allergy- Animals	❑ Yes ❑ No	❑ Yes ❑ No	
Other *(Please list)*	*Details:*		
Name of Participant/Parent or Guardian:			
Signature:		Date:	