



Medical Form – Under 18 Years of Age

Section 1 – General Information

NAME OF PARTICIPANT	DOB	AGE	<input type="checkbox"/> Male	<input type="checkbox"/> Female
HOME ADDRESS				POSTCODE
EMAIL ADDRESS			HOME PHONE	MOBILE
MEDICARE NO	PRIVATE HEALTH FUND	AMBULANCE SUBSCRIBER?		<input type="checkbox"/> Yes <input type="checkbox"/> No
SCHOOL	COURSE DATES FROM	TO	Stage 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	

Emergency Contacts

CONTACT PERSON 1	RELATIONSHIP		
PHONE (WORK)	PHONE (HOME)	MOBILE	
CONTACT PERSON 2	RELATIONSHIP		
PHONE (WORK)	PHONE (HOME)	MOBILE	

Dietary Requirements

List any special dietary requirements your child may have

Medications

Is your child on any prescribed medication? If yes... Yes No

CONDITION	MEDICATION NAME	DOSAGE	TIME TAKEN & FREQUENCY
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Wollangarra carries the following **'over-the-counter' medicines** in our first aid kits.

As deemed necessary by our Wilderness First Aid trained staff, do you permit your child to be given:

Paracetamol pain relievers (Chemists Own brand or Panadol)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fexofenadine antihistamine (Telfast)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ibuprofen anti-inflammatories (Chemists Own brand or Nurofen)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Promethazine antihistamine (Phenergan)	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Mefanamic Acid period pain reliever (Ponstan)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other

Last Tetanus Immunisation: (must be within 10 years) YEAR

Can your child swim 50m without stopping? No With a struggle Comfortably Strongly

Please indicate any religious observances or medical constraints (eg. No blood transfusions)

Are there any custodial / family / court issues that may affect your child? Yes No

IF YES, PLEASE PROVIDE NECESSARY DETAIL



Medical Conditions – Does your child have or has your child ever suffered from...

Asthma? IF YES COMPLETE SECTION 2 – ASTHMA MANAGEMENT FORM Yes No

Allergies? IF YES COMPLETE SECTION 3 – ALLERGY REACTION MANAGEMENT FORM Yes No
These may include food or food additives, insect bites, medications, plants or pollens, detergents, cleaning agents or others.

Diabetes? IF YES, PLEASE ATTACH SEPARATE DETAILS OF CONDITION Yes No
Include history, normal blood sugar levels for different activities, insulin dependency and frequency of injections, dietary requirements, common signs and symptoms in lead up to hypoglycaemia and hyperglycaemia and contact phone number of treating doctor. Wollangarra requires diabetics to bring their own extra food, two glucometers, and an emergency glucose injection kit.

Epilepsy? IF YES, PLEASE ATTACH SEPARATE DETAILS OF CONDITION Yes No
Include lead up symptoms, frequency, type, medication and contact phone number of treating doctor.

Neck, shoulder, back, hip, knee or ankle injury? Yes No
Include details of Injury (indicate left or right), treatment and current condition.

Migraines? Yes **Headaches?** Yes No
Include details of triggers, symptoms and treatment.

Other Condition? TYPE Yes No
If yes, please supply details including treatment and current status
e.g. vertigo (i.e. feels uncomfortable or sick on elevators/escalators/near cliff edges); sleep walking; emotional or behavioural disorders; any other physical disabilities or disorders (e.g. back problems, impaired vision / hearing / speech / mobility / touch / smell).

Recent Illness / Injury / Surgery? TYPE Yes No
If yes, please supply details including treatment and current status

Authorisation TO BE COMPLETED BY PARENT / GUARDIAN

NAME OF PARTICIPANT	NAME OF PARENT / GUARDIAN	DATE
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In the event of any illness or injury, I authorise the obtaining, on my behalf, such medical assistance as my child may require. I declare that my child's tetanus immunisation is current.
I agree to cover any medical costs that may arise, including Ambulance (Air Ambulance) costs.
I have declared all the information that has been required.

SIGNATURE

Privacy Statement

Wollangarra maintains a commitment to ensuring that all information, including medical details, gathered by the centre, or provided by the group leader, will remain confidential, and will only be used for the purpose for which it was intended.



Section 2 – Asthma Management Form COMPLETE IF YOU TICKED 'YES' FOR ASTHMA ON PAGE 2

Has your child been admitted to hospital due to asthma in the past 12 months? Yes No

Has your child been on oral cortisone within the past 12 months? Yes No

Prednisolone Cortisone Prednisone Betamethasone
Other PLEASE DESCRIBE

Has your child suffered severe asthma attacks requiring hospitalisation? Yes No

If so, when was the last? DATE

What are the student's usual symptoms of asthma?

Wheezing Tightness in chest Coughing Difficulty in breathing

Other PLEASE DESCRIBE

Is your child on preventers? Yes No

DETAILS

Usual asthma management plan followed by your child:

Medication and treatment to be used during worsening asthma:

Medication and treatment to be used during crisis situations:

List any known trigger factor(s) experienced by your child

If known, please complete the following Peak Flow Readings: BEST: CRITICAL:

Section 3 – Allergy Reaction Management Form COMPLETE IF YOU TICKED 'YES' FOR ALLERGIES ON PAGE 2

To what is your child allergic?

What are the signs and symptoms of the allergic reaction?

Has your child at any time in the past suffered from:

Localised reaction (any rash, itching, swelling at the site the toxin has entered) Yes No

Systemic reaction (any rash, itching, swelling away from the site where the toxin has entered) Yes No

Anaphylactic reaction (severe breathing problems, swelling of the body, emergency situation) Yes No

If there has been an anaphylactic reaction in the past, please attach your child's Anaphylaxis plan from your family doctor.

What medication does your child take to prevent allergic reaction?

What treatment is followed for your child if an allergic reaction occurs?

Authorisation TO BE COMPLETED BY PARENT / GUARDIAN

NAME OF PARTICIPANT NAME OF PARENT / GUARDIAN DATE

The information on this form is true to the best of my knowledge. SIGNATURE