Wollangarra
Outdoor Education Centre

Medical Form – Over 18

Section 1 – General Information

FULL NAME	DOB	AGE	☐ Male ☐ Female
HOME ADDRESS			POSTCODE
EMAIL ADDRESS	WORK PHONE	HOME PHONE	MOBILE
MEDICARE NO / PRIVATE HEALTH FUND? PROVIDER:	☐ Yes ☐ No	HEALTH CARE CARD? CARD NUMBER:	☐ Yes ☐ No
AMBULANCE SUBSCRIBER?	☐ Yes ☐ No		
CAPACITY OF INVOLVEMENT?	COURSE PARTICIPANT ☐	SCHOOL STAFF MEMBER ☐	VOLUNTEER ☐
OTHER (DETAIL) ☐	COURSE DATES FROM	TO	Stage 1 ☐ 2 ☐ 3 ☐

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 you may have

Medications

Are you on any prescribed medication? If yes… ☐ Yes ☐ No

CONDITION	MEDICATION NAME	DOSAGE	TIME TAKEN & FREQUENCY

Other

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

Can you swim 50m without stopping? ☐ No ☐ With a struggle ☐ Comfortably ☐ Strongly

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

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.

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Medical Conditions – Do you, or have you 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 or Hypoglycaemia? 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.

Blood pressure problems? IF YES, PLEASE SUPPLY DETAILS INCLUDING TREATMENT AND CURRENT STATUS ☐ Yes ☐ No

Heart related problems? IF YES, PLEASE SUPPLY DETAILS INCLUDING TREATMENT AND CURRENT STATUS ☐ Yes ☐ No.

Epilepsy or seizures? 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. feel 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

NAME DATE

SIGNATURE

In the event of any illness or injury, I authorise the obtaining, on my behalf, such medical assistance as I may require. I declare that my 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.

Section 2 – Asthma Management Form

COMPLETE IF YOU TICKED 'YES' FOR ASTHMA ON PAGE 2

Have you been admitted to hospital due to asthma in the past 12 months? ☐ Yes ☐ No

Have you been on oral cortisone within the past 12 months? ☐ Yes ☐ No

Prednisolone ☐ Cortisone ☐ Prednisone ☐ Betamethasone ☐

Other ☐ PLEASE DESCRIBE

Have you suffered severe asthma attacks requiring hospitalisation? ☐ Yes ☐ No

If so, when was the last? DATE

What are your usual symptoms of asthma?

Wheezing ☐ Tightness in chest ☐ Coughing ☐ Difficulty in breathing ☐

Other ☐ PLEASE DESCRIBE

Are you on preventers? ☐ Yes ☐ No

DETAILS

Usual asthma management plan:

Medication and treatment to be used during worsening asthma:

Medication and treatment to be used during crisis situations:

List any known trigger factor(s)

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 are you allergic?

What are the signs and symptoms of the allergic reaction?

Have you 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 Anaphylaxis plan from your family doctor.

What medication do you take to prevent allergic reaction?

What treatment do you follow if an allergic reaction occurs?

Authorisation

NAME DATE

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