

Protecting Your Privacy

Protecting your privacy is important to us. The information we seek allows us to manage risk, provide reasonable care and administer 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 need it to enable them to perform their agreed activities (e.g. the First-Aider-In-Charge). You are welcome to contact our office in relation to issues regarding your personal information and for a copy of our Privacy Policy.

We only ask for information that is necessary for the purposes outlined in this statement. In some circumstances, if you don't provide us with all requested information, you could miss the opportunity to be involved in our program.

Program: _____

Personal Contact Details

Given Name _____ Surname: _____

Preferred Name _____ Male Female Date of Birth: _____

Address _____

Suburb _____ Postcode _____ Phone () _____

Do you consent to appropriate use by us of photographs taken on the program that include you? For example, inclusion in our newspaper, placement on our web page or in a brochure Yes No

Program Preparation Details

Dietary Requirements:

Do you have any special dietary requirements? Yes No

If so, please list them: (We will endeavour to meet these requirements, and will contact you if necessary)

Can you swim? (tick one) No Fair Swimmer Good Swimmer
 Yes No

Are you subject to sleep walking?

Safety and Care Details

In case of an emergency, please list phone numbers where a friend or relative may be contacted during the course of the program.

Name	Relationship	Phone Number
_____	_____	_____

Information on Relevant Conditions

Are there any conditions which require special attention that we should know about, e.g. hearing or sight impairment, mental health issues, formal counselling situations, or any other? *Please list below:*

Medical Information

Please give details of your medical insurance if applicable

Insurance Provider: _____ Membership Number: _____

Medicare Number: _____ Number of person on Medicare Card: ____ Expiry Date: _____

Do you have ambulance cover? Yes No

Health Care Card Number (if applicable): _____

Important: Please note that in regards to non-prescription medications such as paracetamol (e.g. Panadol), it is our policy that leader team members do not provide medications.

Will you need to take any tablets or other medication during the course of the program? Yes No

If yes, please give details: _____

Have you been taken off medication recently? If yes, please give details? Yes No

What is the year of your last tetanus injection? _____

Have you previously broken/fractured any bones? If Yes, please give details: Yes No

Specific Medical Conditions

Please indicate if you have had any of the conditions below. Provide additional details if necessary.

Condition	In the Past	Present	Details: e.g. severity, last injection, treatment	Condition	In the Past	Present	Details: e.g. severity, last injection, treatment
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>		Hypo activity	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>		Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	
Fits/Convulsion	<input type="checkbox"/>	<input type="checkbox"/>		Allergy – foods	<input type="checkbox"/>	<input type="checkbox"/>	
Faint/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>		Allergy – animal	<input type="checkbox"/>	<input type="checkbox"/>	
Glandular Fever	<input type="checkbox"/>	<input type="checkbox"/>		Allergy – other	<input type="checkbox"/>	<input type="checkbox"/>	

Particular Activities

In attending the program, you consent to participation in a range of general sporting and recreational activities. If potentially risky activities of a specific nature are included, the Team Leader will inform you of these.

Are there any specific activities that you do not wish to participate in? Yes No

If yes, please specify: _____

Your Agreement with the Organisation

I am aware, in signing this document regarding my participation in this program, that certain elements of the program could be physically and emotionally demanding. Furthermore, I understand that certain inherent risks and dangers exist in the activities in which I will be participating. I acknowledge that while the organisation and its leaders will make every reasonable effort to minimise exposure to known risks, all hazards and dangers associated with these activities cannot be foreseen or may be beyond the control of the organisation, its leaders and staff. In the event of any emergency where my nominated contact people are unavailable:

1. I authorise the leaders to obtain medical advice and/or assistance which they deem necessary.
2. I further authorise qualified practitioners to administer anaesthetic if required.
3. I accept all operation, blood transfusion and/or anaesthetic risks involved in the event that such procedures are deemed necessary.
4. I accept the responsibility for payment and agree to pay medical, transport and any other related expenses.
5. I confirm that the information contained in this application is true and correct.
6. I agree to inform the leader of any change to these details.

Name of Applicant _____

Signature of Applicant _____

Date _____

Resource: 18+ Medical and Personal Information
Level: Team Leader
Resource Code CSE2-MA

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