

Medical & Personal Information Form (under 18)



bringing hope to a young generation

CONFIDENTIAL

Protecting Your Privacy

Protecting your privacy is important to us. The information we seek allows us to manage risk, provide reasonable care and administrate your involvement in our program. We are careful to keep your information confidential, and provide it only to those agents acting on behalf of SU QLD who need it to enable them to perform their agreed activities (e.g. First Aid officer). We will not use your information for other purposes. 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.

PLEASE RETURN THIS FORM TO THE EVENT DIRECTOR PRIOR TO THE EVENT

(nb: If this form is not received by the due date we cannot guarantee a place on the program)

Program Applied for: Sunshine Coast Schoolies 2009

Personal Contact Details

Child's Given Name _____ Surname: _____

Preferred Name _____ Male Female Date of Birth: _____

Address _____

Suburb _____ Postcode _____

Contact Details Home () _____ Child's mobile _____

Do you consent to your child's contact details being included on the contact list provided to participants? Yes No

Do you consent to appropriate use by SU QLD of photographs taken on the program that include your child? Yes No
For example, inclusion in our quarterly "Transform" Publication, placement on our web page or in a brochure, promotion in local newspaper publications, inclusion in school chaplaincy newsletters

Do you consent to a leader continuing contact with your child after the event, within SU policy guidelines and with your full knowledge of details and purpose? Yes No

Program Preparation Details

Transport details

How will you be getting to camp? Camp Bus Private Car/Other

How will you be getting home from camp? Camp Bus Private Car/Other

If camp bus, please indicate which stop?

Dietary Requirements

Does your child have any special dietary requirements? Yes No

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

Can your child swim? (tick one) No Fair Swimmer Good Swimmer

Is your child subject to sleep walking? Yes No

Is your child subject to bed wetting? Yes No

Safety and Care Details

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

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

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

(Please turn over)

school chaplaincy

camps

training

resources

community outreach

at-risk youth



Medical Information

Please give details of your child's medical insurance if applicable

Insurance Provider _____ Membership Number: _____

Please list your Medicare Number: _____ Number on card: _____ Expiry Date: _____

Can your child be given Panadol as a pain killer? Yes No

Will your child need to take any tablets or other medication during the course of the program? Yes No
If yes, please list the medication & details of dosage on the attached form

The Medication Officer will keep all medication in a secure place and will administer it to your child as needed. Do you consent to this process? If not, please detail how medication will be administered? Yes No

Has your child been taken off medication recently? If yes, please give details? Yes No

What is the year of your child's last tetanus injection? _____

Has your child previously broken/fractured any bones? If Yes, please give details: Yes No

Specific Medical Conditions

Please indicate in the relevant columns if your child has had any of the following. 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"/>		Hypoactivity	<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/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>		Allergy - foods	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>		Allergy - animals	<input type="checkbox"/>	<input type="checkbox"/>	
Glandular Fever	<input type="checkbox"/>	<input type="checkbox"/>		Allergy - other	<input type="checkbox"/>	<input type="checkbox"/>	
Other illnesses:	_____						

Particular Activities

In attending the program, you consent to your child's participation in a range of general sporting and recreational activities. If specific risk-oriented activities are included, the program will have informed you of these.

Are there any specific activities that you do not wish your child to participate in? Yes No
If yes, please specify:

Do you consent to your child travelling in a leader's car (over 21yrs old), which is comprehensively insured, for medical or necessary program transportation? The Event Director will veto all use of any leader's cars and will only request their use if absolutely necessary. Yes No

Your Agreement With Scripture Union

I am aware in signing this document for my child's participation this program that certain elements of the program could be physically and emotionally demanding. Furthermore, I understand that certain inherent risks and dangers may exist in the activities in which my child will be participating. I acknowledge that while Scripture Union 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 Scripture Union, its leaders and staff. In the event of any emergency where my nominated contact person are unavailable:

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

Name of Parent/Guardian (please circle)

Signature of Parent/Guardian

Date

2008

school chaplaincy

camp

training

resources

community outreach

at-risk youth



Medication Form - u18



Name of Program applied for:

bringing hope to a young generation

If it is necessary for your child to take medication during the event, please complete the following information. If there is not enough room, please photocopy this form before completing and attach the other pages with this one.

Participant's Name:	
Name of medication:	
Dosage of medication:	
Time of day medication is to be administered:	
Period of time medication is to be administered (<i>max 1 week</i>):	
Reason for medication:	
Doctor's name:	
Doctor's telephone number:	

NOTE: All prescription medication must come in a package clearly labeled by a chemist at the doctor's direction with your child's name, dosage and instructions for dispensing.

Please attach this form with the medical form and return to the Event Director

(nb: If this form is not received by the due date we cannot guarantee a place on the program)

school chaplaincy

camps

training

resources

community outreach

at-risk youth



Scripture Union Queensland is a member of the worldwide Scripture Union International community

© SU QLD 2008
Version 2.4/08