



Health profile and medical consent

This profile is designed to assist with the care of all participants on EOTC events, including adults. One form to be completed for EACH participant.

Name: _____ Medic Alert Number: _____ (if applicable)

1. Please tick if you have any of the following:

- | | | | | | |
|---------------------|--------------------------|------------------------|--------------------------|------------------|--------------------------|
| Migraine | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | Asthma | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Travel sickness | <input type="checkbox"/> | Fits of any type | <input type="checkbox"/> |
| Chronic nose bleeds | <input type="checkbox"/> | Heart condition | <input type="checkbox"/> | Dizzy spells | <input type="checkbox"/> |
| Colour blindness | <input type="checkbox"/> | Other (Please specify) | _____ | | |
| ADHD | <input type="checkbox"/> | | | | |

For overnight events

- | | | | |
|--------------|--------------------------|------------|--------------------------|
| Sleepwalking | <input type="checkbox"/> | Bedwetting | <input type="checkbox"/> |
|--------------|--------------------------|------------|--------------------------|

2. Are you/your child currently taking medication? Yes No

If YES, please state: Health condition/s: _____

Name of medication/s: _____

Dosage and time/s to be taken: _____

Other Treatment: _____

3. Is a health plan required? Yes No [Go to Sample form 9](#)

Have you had any major injuries (breaks or strains) or illness (glandular fever etc) in the last six months that may limit full participation in any activities?

Yes No

If YES, please state the injury/illness:

4. Are you allergic to any of the following?

- | | Yes | No | Please specify |
|-------------------------|--------------------------|--------------------------|----------------|
| Prescription medication | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Food | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Insect bites/stings | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other allergies | <input type="checkbox"/> | <input type="checkbox"/> | _____ |



What treatment is required? _____

5. When was your /your child's last tetanus injection? _____

6. Outline any dietary requirements:

7. What pain/flu medication may your child be given if necessary?

8. To the best of your knowledge. Have you/your child been in contact with any contagious or infectious diseases in the last four weeks?

Yes No

If YES, please give brief details

9. Is there any information the staff should know to ensure the physical and emotional safety of you/your child? (For example cultural practices; disability; anxiety; about heights/darkness/small spaces; pregnancy; behaviour or emotional problems).

Yes No

If YES, please state or attach the information.

Tick

- I agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened and handed to the designated adult with instructions on its administration.
- I will inform the school as soon as possible of any changes in the medical or other circumstances between now and the commencement of the event.
- I agree to my child/myself receiving any emergency medical, dental, or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.
- Any medical costs not covered by ACC or a community service card will be paid by me.
- If my child is involved in a serious disciplinary problem, including the use of illegal substances and/or alcohol, or actions that threaten the safety of others, s/he will be sent home at my expense.

To be read and signed by adult participant or parent/caregiver of child participant.

Signature _____

Name: _____ Date: _____

THIS FORM OR A COPY MUST BE TAKEN ON THE EVENT. A COPY SHOULD BE RETAINED BY THE SCHOOL CONTACT

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