**TEAM MEMBER 18+ MEDICAL INFORMATION FORM**

**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, stored securely and provide it only to those agents acting on behalf of the CFC who need it to enable them to perform their agreed activities (e.g. a Team Member providing First Aid). We only ask for information that is necessary for the purposes outlined in this statement. If you would like a copy of our* ***CFC Child & Youth C.A.R.E Policy*** *please contact:*

**Church:**   **Office Phone:**  **Email:**

**PERSON’S PERSONAL INFORMATION:**

|  |  |  |
| --- | --- | --- |
|  **NAME** | First:  | Last:  |
| **HOME ADDRESS** |   **P/CODE**:  |
| **DATE OF BIRTH** |  |

**CONTACT NUMBERS**:

|  |  |
| --- | --- |
| **PHONE** **NUMBERS** | Mobile:Other:  |
| Email:  |  |

**MEDICAL INFORMATION:**

|  |  |
| --- | --- |
| **MEDICARE NUMBER:** |  |
| **FAMILY DOCTOR/CLINIC** (Name & Address)**:** Doctor/Clinic’s Phone No:  |

**Please tick the following if this applies to you:**

Are you covered by a private medical benefit fund? ***[ ]*** Yes ***[ ]*** No

If yes, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from anything we should know about if medical assistance is required?

***[ ]*** Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[ ]*** Severe allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[ ]*** Dietary needs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[ ]*** Convulsive seizures, etc? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[ ]*** Physical needs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[ ]*** Do you have any regular prescribed medicine? If so, please give details to assist emergency services in the event of an emergency where you required immediate medical attention:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been in contact with anyone with any 'communicable disease', e.g., measles, mumps, chicken pox, within the last 21 days? ***[ ]  Yes [ ]  No* If so, which one?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any other information – or health plan - which might assist with helping you if required? Please give details:

**ALTERNATIVE EMERGENCY CONTACT*:***

|  |  |  |
| --- | --- | --- |
| **NAME** |   | **RELATIONSHIP TO YOU**  |
| **PHONE NUMBERS** | Mobile: Work:  | Home:  |

**MEDICAL CONSENT:**

***By signing this Medical Information Form you understand / agree that:***

* Team Leaders for this CFC program have your consent to take whatever action necessary to ensure your safety .
* If you become ill or are injured, Team Leaders may obtain on your behalf whatever medical treatment is deemed necessary. You also agree to pay for such medical expenses.
* If you fail or neglect to provide sufficient and current information in writing to enable proper treatment, no liability will be accepted for any injury or illness, which you may suffer as a result.
* Your own doctor or may be contacted in the case of any emergency. An ambulance may be called in the case of an emergency.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_