**U18 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 child / young person’s 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 church 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. In some circumstances, if you don't provide us with all requested information, your child/young person could miss the opportunity to be involved in our program. If you would like a copy of our* ***Duty of Care & Child Protection Policy*** *please contact:*

**Church:** **Office Ph:** **Email:**

**CHILD / YOUNG PERSON’S PERSONAL INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** *(please print)* | First: | Last: | |
| **HOME ADDRESS** | **P/CODE**: | | |
| **DATE OF BIRTH** |  | **AGE:** | **GRADE:** |

**PARENT/CARER CONTACT NUMBERS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | Parent/Carer 1: |  | Parent/Carer 2 (if applicable): |
| **PHONE** | Home/Mobile: |  | Home/Mobile: |
| Work: | |  | Work: |
| Email: | |  | Email: |

**MEDICAL INFORMATION:**

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

***Please tick the following if any* *apply to your child/young person:***

Is your child or young person covered by a private medical benefit fund? *[This is helpful information for us to pass on to care providers in an emergency situation and or where a hospital admission may be required]* YesNo

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

Does your child or young person suffer from anything Team Leaders should know about to assist in their care?

Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severe allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dietary needs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Convulsive seizures, etc? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical needs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child/young person have any regular prescribed medicine? **If yes, please give details:**

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

*[Note: Any medicine/tablets needed during the time your child is registered in a church program should be handed in their original packaging to a Team Leader together with: name of child, dosage required & time and specific details of administration.]*

Has your child/young person 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 your child / young person fully up to date with their immunizations for their age? ***(Please tick)***

**Yes**  **No** Date of the last Tetanus immunization for your child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*[If no, by signing this form you understand that you or the alternative contact person you nominate below will be required to promptly withdraw your child from our program should we become aware of any ‘communicable disease’ to which they may have unknowingly been exposed.]*

Is there any other information / health plan we should know about to assist us with caring for your child/young person?

**Please give details:**

**ALTERNATIVE EMERGENCY CONTACT*: (if parent/carers 1 and/or 2 cannot be contacted)***

|  |  |  |
| --- | --- | --- |
| **NAME** |  | **RELATIONSHIP TO CHILD/YOUNG PERSON** |
| **PHONE NUMBERS** | Home:  Work: | Mobile: |

**MEDICAL CONSENT:**

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

* Team Leaders for this program have your consent to take whatever action necessary to ensure the safety and wellbeing of the group or individual participants under their care (this includes your child).
* If your child becomes ill or is injured and you cannot or your nominated alternative emergency contact person(s) cannot be contacted, Team Leaders may obtain on your behalf whatever medical treatment is deemed necessary. You also agree to pay for such medical expenses.

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Parent /Carer)

* If you fail or neglect to provide sufficient and current information in writing to enable the proper treatment of your child, no liability will be accepted for any injury or illness, which your child may suffer as a result.
* Your child’s own doctor or may be contacted in the case of any emergency.
* An ambulance may be called in the case of an emergency.
* Should any of your child’s medical information change you will inform us as soon as possible.

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_