Student Medical Form pg.1

Personal Details

First Name _____ **Middle Name** _____ **Last Name** _____

Date of Birth / / **Age** **Gender** MALE/FEMALE

Height _____ m **Weight** _____ kg

Residential Address _____ **Post Code** _____

Emergency Contact #1

First Name _____ **Last Name** _____ **Relationship** _____

Home Phone _____ **Work Phone** _____ **Mobile Phone** _____

Residential Address _____ **Post Code** _____

Email Address _____

Emergency Contact #2

First Name _____ **Last Name** _____ **Relationship** _____

Home Phone **Work Phone** **Mobile Phone**

Residential Address _____ **Post Code** _____

Email Address _____

Medical Information

Medicare Number _____ **Doctors Name** _____ **Doctors Phone #** _____

Medical Fund Name _____ **Membership Number** _____

Medical Cover Provider _____ **Membership Number** _____

Ambulance Cover Provider _____ **Membership Number** _____

Date of last tetanus injection / / (If not current, see doctor)

Does your child currently require medication? Yes – complete medication form No

Does your child suffer from asthma? Yes – complete asthma management form No

Does your child suffer from allergies? Yes – complete allergy management form No

Does your child suffer from any of the following? (circle and complete details is applicable)

Chronic injury	No	Yes	Details: _____
Chronic illness	No	Yes	Details: _____
Emotional Disorder	No	Yes	Details: _____
Behavioural Disorder	No	Yes	Details: _____
Low/High Blood Pressure	No	Yes	Details: _____
Heart Complications	No	Yes	Details: _____
Phobias	No	Yes	Details:

Student Medical Form pg. 2

Students Name: _____

Bedwetting	No	Yes	Details:	
Sleepwalking	No	Yes	Details:	
Travel Sickness	No	Yes	Details:	
Dietary Requirements	No	Yes	Details	

If your child is ill or requires medical attention in the 4 weeks prior to program you must provide a medical certificate deeming your child fit for program.

Swimming Skills

Please indicate your child's swimming skills below:

Swimming Skill	✓
Poor – Basic strokes, only limited strokes beyond domestic swimming pool	
Able – Nothing more than dog paddle	
Good – Strong swimmer, able to swim confidently in a variety of water conditions	
Excellent – Very strong and confident, could swim 50 metres fully clothed	

Mountain Biking Skills

Please indicate your child's mountain biking below:

Mountain Biking Skill	✓
Non-rider – hasn't yet learned to ride a bike	
Poor – basic riding on flat ground only	
Good – can ride on varied terrain, use gears and brakes effectively	
Excellent – very strong and confident, on all terrain including jumps and drops	

Student Medication Form

I, _____

(Parent/Guardian's Name)

Give permission for medication to be administered to _____

(Students Name)

Name of Medication	Reason/Purpose for Medication	Instructions for Administering	Amounts	Times/day

Please Note: Container must be clearly marked with your name, dosage and instruction's for dispensing.

In the unlikely event that your child/ward misses the allocated time, what steps would you like taken (e.g. administer medication straight away, call you, call Emergency Help)?

1.

2.

3.

4.

5.

Is your child/ward familiar with taking this medication? YES NO

I understand that, while Barrington Outdoor Education staff and instructors may be prepared to assist in this matter, the ultimate responsibility rests with me as parent/guardian.

If there are any problems with the child/ward taking medication, parents/guardians will be contacted immediately.

Parent/Guardians Name	Parent/Guardians Signature	Date

Student Asthma Management Form

I, _____

(Parent/Guardian's Name)

Give permission for below plan to be followed for _____

(Students Name)

Preventer (if prescribed)	**Use**	**Times/day**
Reliever	**Use**	**Times/day**
Symptom controller (if prescribed)	**Use**	**Times/day**
Before exercise	**Use**	**Times/day**
Additional medication to be taken in the event of significant wheeze or cough	**Use**	**Times/day**
Emergency medication	**Use**	**Times/day**

Known Trigger Factors (please circle and add details if applicable)

Dust of any sort in sufficient quantities	Yes	No
Sudden change in temperature	Yes	No
Contact with animals	Yes	No
Grass and weed pollens, mould	Yes	No
Vigorous exercise	Yes	No
Atmospheric pollution	Yes	No

Other – Details No Yes Details: _____

Student Allergy Management Form

Students Name _____

What is your child/ward allergic to? _____

What are the signs and symptoms of the reaction? _____

Medication and treatment during an emergency attack? _____

Has your child/ward previously suffered from any of the following:

Localised reaction (Rash, itching, swelling)	Yes	No
A systemic reaction (Rash, itching, swelling)	Yes	No
An anaphylactic reaction (severe breathing problem, total body swell, emergency situation)	Yes	No
Have you been admitted to hospital due to allergies in the last 12 months	Yes	No
Is there a history of anaphylaxis in your family?	Yes	No
Has allergies interfered with participation in normal physical activities within the last 12 months?	Yes	No
Does your child/ward carry + take adrenaline (Epi-pen), when suffering an allergic reaction? If YES they MUST bring their Epi-pen/Anapen on camp	Yes	No