Wollangarra
Outdoor Education Centre

Medical Form – Under 18 Years of Age

Section 1 – General Information

NAME OF PARTICIPANT | DOB | AGE | ☐ Male ☐ Female

HOME ADDRESS | POSTCODE

EMAIL ADDRESS | HOME PHONE | MOBILE

MEDICARE NO | PRIVATE HEALTH FUND | AMBULANCE SUBSCRIBER? ☐ Yes ☐ No

SCHOOL | COURSE DATES FROM | TO | Stage 1 ☐ 2 ☐ 3 ☐

Emergency Contacts

CONTACT PERSON 1 | RELATIONSHIP

PHONE (WORK) | PHONE (HOME) | MOBILE

CONTACT PERSON 2 | RELATIONSHIP

PHONE (WORK) | PHONE (HOME) | MOBILE

Dietary Requirements

List any special dietary requirements your child may have

Medications

Is your child on any prescribed medication? If yes… ☐ Yes ☐ No

CONDITION | MEDICATION NAME | DOSAGE | TIME TAKEN & FREQUENCY

Wollangarra carries the following **'over-the-counter' medicines** in our first aid kits.
As deemed necessary by our Wilderness First Aid trained staff, do you permit your child to be given:

Paracetamol pain relievers (Chemists Own brand or Panadol) ☐ Yes ☐ No

Ibuprofen anti-inflammatories (Chemists Own brand or Nurofen) ☐ Yes ☐ No

Fexofenadine antihistamine (Telfast) ☐ Yes ☐ No

Promethazine antihistamine (Phenergan) ☐ Yes ☐ No

Mefanamic Acid period pain reliever (Ponstan) ☐ Yes ☐ No

Asprin ☐ Yes ☐ No

Other

Last Tetanus Immunisation: (must be within 10 years) | YEAR

Can your child swim 50m without stopping? ☐ No ☐ With a struggle ☐ Comfortably ☐ Strongly

Please indicate any religious observances or medical constraints (eg. No blood transfusions)

Are there any custodial / family / court issues that may affect your child? ☐ Yes ☐ No

IF YES, PLEASE PROVIDE NECESSARY DETAIL

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Medical Conditions – Does your child have or has your child ever suffered from…

Asthma? IF YES COMPLETE SECTION 2 – ASTHMA MANAGEMENT FORM ☐ Yes ☐ No

Allergies? IF YES COMPLETE SECTION 3 – ALLERGY REACTION MANAGEMENT FORM ☐ Yes ☐ No
These may include food or food additives, insect bites, medications, plants or pollens, detergents, cleaning agents or others.

Diabetes? IF YES, PLEASE ATTACH SEPARATE DETAILS OF CONDITION ☐ Yes ☐ No
Include history, normal blood sugar levels for different activities, insulin dependency and frequency of injections, dietary requirements, common signs and symptoms in lead up to hypoglycaemia and hyperglycaemia and contact phone number of treating doctor. Wollangarra requires diabetics to bring their own extra food, two glucometers, and an emergency glucose injection kit.

Epilepsy? IF YES, PLEASE ATTACH SEPARATE DETAILS OF CONDITION ☐ Yes ☐ No
Include lead up symptoms, frequency, type, medication and contact phone number of treating doctor.

Neck, shoulder, back, hip, knee or ankle injury? ☐ Yes ☐ No
Include details of Injury (indicate left or right), treatment and current condition.

Migraines? ☐ Yes **Headaches?** ☐ Yes ☐ No
Include details of triggers, symptoms and treatment.

Other Condition? TYPE ☐ Yes ☐ No
If yes, please supply details including treatment and current status
e.g. vertigo (i.e. feels uncomfortable or sick on elevators/escalators/near cliff edges); sleep walking; emotional or behavioural disorders; any other physical disabilities or disorders (e.g. back problems, impaired vision / hearing / speech / mobility / touch / smell).

Recent Illness / Injury / Surgery? TYPE ☐ Yes ☐ No
If yes, please supply details including treatment and current status

Authorisation

TO BE COMPLETED BY PARENT / GUARDIAN

NAME OF PARTICIPANT NAME OF PARENT / GUARDIAN DATE

SIGNATURE

In the event of any illness or injury, I authorise the obtaining, on my behalf, such medical assistance as my child may require. I declare that my child's tetanus immunisation is current.
I agree to cover any medical costs that may arise, including Ambulance (Air Ambulance) costs.
I have declared all the information that has been required.

Privacy Statement

Wollangarra maintains a commitment to ensuring that all information, including medical details, gathered by the centre, or provided by the group leader, will remain confidential, and will only be used for the purpose for which it was intended.

Section 2 – Asthma Management Form

COMPLETE IF YOU TICKED 'YES' FOR ASTHMA ON PAGE 2

Has your child been admitted to hospital due to asthma in the past 12 months? ☐ Yes ☐ No

Has your child been on oral cortisone within the past 12 months? ☐ Yes ☐ No

Prednisolone ☐ Cortisone ☐ Prednisone ☐ Betamethasone ☐

Other ☐ PLEASE DESCRIBE

Has your child suffered severe asthma attacks requiring hospitalisation? ☐ Yes ☐ No

If so, when was the last? DATE

What are the student's usual symptoms of asthma?

Wheezing ☐ Tightness in chest ☐ Coughing ☐ Difficulty in breathing ☐

Other ☐ PLEASE DESCRIBE

Is your child on preventers? ☐ Yes ☐ No

DETAILS

Usual asthma management plan followed by your child:

Medication and treatment to be used during worsening asthma:

Medication and treatment to be used during crisis situations:

List any known trigger factor(s) experienced by your child

If known, please complete the following Peak Flow Readings: BEST: CRITICAL:

Section 3 – Allergy Reaction Management Form

COMPLETE IF YOU TICKED 'YES' FOR ALLERGIES ON PAGE 2

To what is your child allergic?

What are the signs and symptoms of the allergic reaction?

Has your child at any time in the past suffered from:

Localised reaction (any rash, itching, swelling at the site the toxin has entered) ☐ Yes ☐ No

Systemic reaction (any rash, itching, swelling away from the site where the toxin has entered) ☐ Yes ☐ No

Anaphylactic reaction (severe breathing problems, swelling of the body, emergency situation) ☐ Yes ☐ No

If there has been an anaphylactic reaction in the past, please attach your child's Anaphylaxis plan from your family doctor.

What medication does your child take to prevent allergic reaction?

What treatment is followed for your child if an allergic reaction occurs?

Authorisation

TO BE COMPLETED BY PARENT / GUARDIAN

NAME OF PARTICIPANT NAME OF PARENT / GUARDIAN DATE

The information on this form is true to the best of my knowledge. SIGNATURE