

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Camp 2021 - Confidential Health Profile and Medical Consent** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Name:** |  | | | | | | | | **Room:** |  | | |
|  | | | | | | | | | | | | |
| **1. Please tick if your child has any of the following:(if applicable)** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Asthma** | | |  | **Epilepsy** | |  | **Skin Condition** | | | |  |
|  | | | | | | | | | | | | |
| **Diabetes** | | |  | **Travel sickness** | |  | **Fits of any type** | | | |  |
|  | | | | | | | | | | | | |
| **Chronic nose bleeds** | | |  | **Heart condition** | |  | **Dizzy spells/Blackouts** | | | |  |
|  | | | | | | | | | | | | |
| **Colour blindness** | | |  | **Migraine** | | | |  | | | | |
|  | | | | | | | | | | | | |
| **ADHD** | | |  | **Other Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |  |
| **For overnight events:** | | | | | | | | | | | | |
| **Sleepwalking** | |  | **Bedwetting** | |  |  | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| **2. Is your child currently taking long term 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** | | |  |  | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **4. Has your child 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:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **5. Is your child allergic to any of the following?** | | | | | | | | | | | | | | | |
|  | | | | | | **Yes** | | | |  | **No** | | |  | **Please specify** |
|  | | | | | | | | | | | | | | | |
| **Prescription medication** | | | | | | | |  |  | | |  |  | |  |
|  | | | | | | | | | | | | | | | |
| **Food** | | | | | | | |  |  | | |  |  | |  |
|  | | | | | | | | | | | | | | | |
| **Insect bites/stings** | | | | | | | |  |  | | |  |  | |  |
|  | | | | | | | | | | | | | | | |
| **Other allergies** | | | | | | | |  |  | | |  |  | |  |
|  | | | | | | | | | | | | | | | |
| **What treatment is required for the allergy:** | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **5. When was your child’s last tetanus injection?** | | | | | | | | | | | | | | |  |
| **6. Outline any dietary requirements:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **7. Do you give permission for the following medication to be administered if necessary?**  **Paracetamol ( Pain relief): Yes No**  **Antihistamine for allergies and insect bites: Yes No** | | | | | | | | | | | | | | | |
| **8. To the best of your knowledge. Has 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 your child? (For example cultural practices; disability; anxiety; about heights/darkness/small spaces; behaviour or emotional problems).** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Yes** |  | **No** |  | **If YES, please state or attach the information.** | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **CAMP 2021**  **CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
|  | **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 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, or actions that threaten the safety of others, I agree that s/he will be brought home.** |
|  | |
| **To be read and signed by parent/caregiver of child participant. Next of kin details for an emergency.** | |
|  | |
| **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Next of Kin:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |