Medical & Personal Information Form (over 18)

CONFIDENTIAL

Protecting Your Privacy
Protecting your privacy is important to us. The information we seek allows us to manage risk, provide reasonable care and administrate your involvement in our program. We are careful to keep your information confidential, and provide it only to those agents acting on behalf of SU QLD who need it to enable them to perform their agreed activities (e.g. First Aid officer). We will not use your information for other purposes. You are welcome to contact our office in relation to issues regarding your personal information and for a copy of our Privacy Policy.
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 you could miss the opportunity to be involved in our program.

IMPORTANT: PLEASE RETURN THIS FORM TO THE EVENT DIRECTOR PRIOR TO THE EVENT
(nb: If this form is not received by the due date we cannot guarantee a place on the program)

Program Applied for: ______________________________

Personal Contact Details

Given Name ____________________ Surname: ____________________

Preferred Name ______________ ☐Male ☐Female Date of Birth: ______________

Address ____

Suburb ____________________ Postcode ______________

Contact Details Home ( ) ______________ Mobile ______________

Do you consent to your contact details being included on the contact list provided to participants? ☐ Yes ☐No

Do you consent to appropriate use by SU QLD of photographs taken on the program? ☐ Yes ☐No
For example, inclusion in our quarterly "Transform" Publication, placement on our web page or in a brochure, promotion in local newspaper publications, inclusion in school chaplaincy newsletters

Program Preparation Details

Transport details
How will you be getting to camp? ☐Camp Bus ☐Private Car/Other

How will you be getting home from camp? ☐Camp Bus ☐Private Car/Other

If camp bus, please indicate which stop?

Dietary Requirements
Do you have any special dietary requirements? ☐Yes ☐No
If so, please list them: (We will endeavour to meet these requirements, and will contact you if there are any problems)

Can you swim? (tick one) ☐No ☐Fair Swimmer ☐Good Swimmer
Are you subject to sleep walking? ☐Yes ☐No

Safety and Care Details

In the event of an emergency, please list phone numbers where a relative or friend may be contacted during the course of the program.

Name	Relationship	Phone Number

Are there any conditions which require special attention we should know about, e.g. hearing or sight impairment, ADD or ADHD, behavioural issues, formal counselling situations, or any other? *Please list below:*

(Please turn over)

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Medical Information
Please give details of your medical insurance if applicable

Insurance Provider ______________________ Membership Number: ______________________

Please list your Medicare Number: ______________ Number on card: ________ Expiry Date: __________

Can you be given Panadol as a pain killer? ☐Yes ☐No

Will you need to take any tablets or other medication during the course of the program? ☐Yes ☐No
If yes, please list the medication & details of dosage on the ***attached form***

For security reasons, the Medication Officer will keep all medication in a secure place and you will be able to access it as needed. Do you consent to this process? If not, please speak to your Event Director. ☐Yes ☐No

Have you been taken off medication recently? If yes, please give details? ☐Yes ☐No

What is the year of your last tetanus injection? ______________

Have you previously broken/fractured any bones? If Yes, please give details: ☐Yes ☐No

Specific Medical Conditions
Please indicate in the relevant columns if you have had any of the following. Provide additional details if necessary.

Condition	*In the Past*	*Present*	*Details: e.g. severity, last injection, treatment*	*Condition*	*In the Past*	*Present*	*Details: e.g. severity, last injection, treatment*
Asthma	☐	☐		Hyperactivity	☐	☐	
Appendicitis	☐	☐		Hypoactivity	☐	☐	
Bronchitis	☐	☐		Heart Problems	☐	☐	
Chicken Pox	☐	☐		Measles	☐	☐	
Diabetes	☐	☐		Mumps	☐	☐	
Ear Infections	☐	☐		Pneumonia	☐	☐	
Epilepsy	☐	☐		Tonsillitis	☐	☐	
Fits/Convulsions	☐	☐		Allergy – foods	☐	☐	
Fainting/Dizziness	☐	☐		Allergy – animals	☐	☐	
Glandular Fever	☐	☐		Allergy - other	☐	☐	

Other illnesses: ______________________

Particular Activities
In attending the program, you consent to participation in a range of general sporting and recreational activities. If specific risk-oriented activities are included, the program will have informed you of these.
Are there any specific activities that you do not wish to participate in? ☐Yes ☐No
If yes, please specify:

Your Agreement With Scripture Union

I am aware in signing this document for my participation this program that certain elements of the program could be physically and emotionally demanding. Furthermore, I understand that certain inherent risks and dangers may exist in the activities in which I will be participating. I acknowledge that while Scripture Union and it's leaders will make every reasonable effort to minimise exposure to known risks, all hazards and dangers associated with these activities cannot be foreseen or may be beyond the control of Scripture Union, it's leaders and staff. In the event of any emergency where my nominated contact people are unavailable:

- I authorise the leaders to obtain medical advice and/or assistance which they deem necessary.
- I further authorise qualified practitioners to administer anaesthetic if required.
- I accept all operation, blood transfusion and/or anaesthetic risks involved in the event that such procedures are deemed necessary.
- I accept the responsibility for payment and agree to pay medical, transport and any other related expenses.
- I confirm that the information contained in this application is true and correct.
- I agree to inform the leader of any change to these details.

Name ______________ Signature ______________ Date ______________

Medication Form – over 18

Name of Program applied for:

If it is necessary for you to take medication during the event, please complete the following information. If there is not enough room, please photocopy this form before completing and attach the other pages with this one.

Full Name:	
Name of medication:	
Dosage of medication:	
Time of day medication is to be administered:	
Period of time medication is to be administered *(max 1 week)*:	
Reason for medication:	
Doctor's name:	
Doctor's telephone number:	

NOTE: All prescription medication must come in a package clearly labeled by a chemist at the doctor's direction with your name, dosage and instructions for dispensing.

Please attach this form with the medical form and return to the Event Director

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