



Medical Form – Over 18

Section 1 – General Information

FULL NAME		DOB	AGE	<input type="checkbox"/> Male	<input type="checkbox"/> Female
HOME ADDRESS				POSTCODE	
EMAIL ADDRESS		WORK PHONE	HOME PHONE	MOBILE	
MEDICARE NO	PRIVATE HEALTH FUND? PROVIDER:	<input type="checkbox"/> Yes <input type="checkbox"/> No	HEALTH CARE CARD? CARD NUMBER:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
AMBULANCE SUBSCRIBER?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
CAPACITY OF INVOLVEMENT?		COURSE PARTICIPANT <input type="checkbox"/>	SCHOOL STAFF MEMBER <input type="checkbox"/>	VOLUNTEER <input type="checkbox"/>	
OTHER (DETAIL) <input type="checkbox"/>	COURSE DATES FROM		TO	Stage 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	

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 you may have

Medications

Are you on any prescribed medication? If yes... Yes No

CONDITION	MEDICATION NAME	DOSAGE	TIME TAKEN & FREQUENCY
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Other

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

Can you swim 50m without stopping? No With a struggle Comfortably Strongly

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

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.



Medical Conditions – Do you, or have you 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 or Hypoglycaemia? 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.

Blood pressure problems? IF YES, PLEASE SUPPLY DETAILS INCLUDING TREATMENT AND CURRENT STATUS Yes No

Heart related problems? IF YES, PLEASE SUPPLY DETAILS INCLUDING TREATMENT AND CURRENT STATUS Yes No.

Epilepsy or seizures? 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. feel 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

NAME _____ DATE _____

In the event of any illness or injury, I authorise the obtaining, on my behalf, such medical assistance as I may require. I declare that my 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.

SIGNATURE _____



Section 2 – Asthma Management Form COMPLETE IF YOU TICKED 'YES' FOR ASTHMA ON PAGE 2

Have you been admitted to hospital due to asthma in the past 12 months? Yes No

Have you been on oral cortisone within the past 12 months? Yes No

Prednisolone Cortisone Prednisone Betamethasone
Other PLEASE DESCRIBE

Have you suffered severe asthma attacks requiring hospitalisation? Yes No

If so, when was the last? DATE

What are your usual symptoms of asthma?

Wheezing Tightness in chest Coughing Difficulty in breathing
Other PLEASE DESCRIBE

Are you on preventers? Yes No

DETAILS

Usual asthma management plan:

Medication and treatment to be used during worsening asthma:

Medication and treatment to be used during crisis situations:

List any known trigger factor(s)

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 are you allergic?

What are the signs and symptoms of the allergic reaction?

Have you 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 Anaphylaxis plan from your family doctor.

What medication do you take to prevent allergic reaction?

What treatment do you follow if an allergic reaction occurs?

Authorisation

NAME DATE

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