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|  | **Visiting Teacher/ Adult Medical and Consent** |
| **School:** |
| **Participants Name** (in full):  |
| **Date of Birth:** | **Religion:** |
| **Telephone**  | **Home:** | **Work:** |
|  | **Mobile:** |  |
|  |  |  |
| **Medicare No:**  | **Ref No:** | **Expiry Date:** |

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| **Medical Information** |
| Tetanus Booster | **Yes/No** | Last Year given:  |
| Measles Vaccination | **Yes/No** |  |
| Asthma | **Yes/No** |  |
| Sinus / Hay fever | **Yes/No** |  |
| Other respiratory problems | **Yes/No** |  |
| Food Allergies (eg: peanuts, lactose | **Yes/No** |  |
| Medical Allergies (eg: penicillin, analgesics) | **Yes/No** |  |
| Epilepsy | **Yes/No** |  |
| Phobias | **Yes/No** |  |
| Heart Conditions | **Yes/No** |  |
| Recent Operations, illness or injuries | **Yes/No** |  |
| Physical Disabilities | **Yes/No** |  |
| Other | **Yes/No** |  |
| Swimming Ability | Non Swimmer 25m 50m 100m |
| Any Special Dietary Requirememnts? |
| **Authorisation for Qualified Practitioners, if required, to administer:*** **Anaesthetic Yes/No** (please circle) **Blood Transfusion Yes/No** (please circle)
 |
| **Emergency Contact:**  |  | Home Phone: |  |
|  |  | Work Phone: |  |
|  |  | Mobile: |  |

* I am aware of the activities that are included in the program.
* I understand that some activities involve a high level of physical activity and are conducted outdoors.
* I have advised the school’s program coordinator, in writing, of my special dietary needs (if any).
* I have completed the attached medical details and clearly outlined current medical information.

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| **Privacy Notice:** Kinchant OEC is collecting information on these forms in accordance with the Department of Education and Training Policies for the purpose of ensuring the health and wellbeing of individuals attending programs at the Centre. These forms will be retained and held securely and will be disposed of when they are no longer required. Some or all of this information may be disclosed to Kinchant OEC staff, school staff and volunteers, Qld Emergency Services Officers, Medical and Health Care Practitioners as deemed necessary. Personal information on this form may be disclosed where authorised or required by law. |

 **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**