



FORM

A – Medical Form

(To be filled in by person with parental responsibility or Adult participant)

To **Southern Cross Presbyterian Church**, The Presbyterian Church of Australia in New South Wales, and the Presbyterian Church (New South Wales) Property Trust (collectively referred to as **Southern Cross Presbyterian Church**)

RE: Medical Information for youth ministry at Southern Cross Presbyterian Church

Please let us know of any medical condition/disability that may be relevant to your welfare and safety on this excursion in accordance with this Medical Form.

1. Name: _____ Age: _____
2. Parent or guardian (please print): _____

3. Place during your stay: *ignore this question, please make sure we can contact you by phone* _____

4. Home Address: _____

5. Home Telephone: _____
Mobile: _____
6. Medicare number: _____
7. Name of Medical Fund: _____

PLEASE TICK IF YOU SUFFER FROM ANY OF THE FOLLOWING

- | | | |
|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Migraine | <input type="checkbox"/> Epilepsy |

8. Do you suffer from asthma? Yes / No
Is it: Mild Moderate Severe
Please list all medications taken both regularly and during an attack: _____

Please list any triggers and any other information that may assist the Organisation's staff: _____

9. Do you suffer from other illnesses or physical disabilities, please describe: _____

10. Do you suffer from any allergies? If so please describe: _____

Are they: Localised Systemic Anaphylactic

Please list all medications taken both pre, during and post a reaction: _____

11. Are you currently taking medication? If so please describe (include dosage, how often taken): _____

12. Can your child swim more than 100 metres?

(Safari/GSAC)

Yes / No



C - Medical Authority

(To be filled in by person with parental responsibility or Adult participant)

MEDICAL AUTHORITY

I _____

please advise relationship if participant under 18 _____

Name of participant if under 18 _____

I am / my child is in good health and there are no special problems associated with his or her care other than those set out above.

All Participants

I authorise any senior person employed by the Organisation to arrange for medical attention for me or to transfer me to a medical centre or to a hospital if, in the opinion of that person, medical attention is needed or is likely to be needed for me.

I acknowledge that every possible effort will be made to contact the Person with parental responsibility at the first available opportunity.

In the event that my child through injury or otherwise, is, in the opinion of the Organisation's personnel in attendance, in need of immediate medical treatment, including surgery and/or the administration of anaesthetics, I hereby give my consent to the Organisation's staff to authorize, in writing or otherwise, the necessary treatment.

I accept all medical treatment risks and the responsibility for payment of any expenses thus incurred, including transportation.

I am aware that the practice of medicine in a surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any related treatment or examinations.

Signature of adult participant or person with parental responsibility. _____

Date: _____



D: OTHER

Dietary Issues

Does your child have any special dietary need that we should know about? No

Care Needs

Does your child have any care or custody need that we should know about? No

subject to a custody order behavioural issues
psychiatric care other

If you ticked any boxes above please provide details:

I consent to my child's photo and or video being taken for the use of Southern Cross Presbyterian church communications, including church run websites and online communication
Yes No