

Medical and consent form – Child

Participant details

First name	Last name	<input type="checkbox"/> Male	Date of birth
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Female	<input type="text"/> / <input type="text"/> / <input type="text"/>
School name	Year group		
<input type="text"/>	<input type="text"/>		
Postal address	Postcode		
<input type="text"/>			

Program details

Program number (if known)	Centre name	Date from	Date to
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Parent/guardian contact details

First name	Last name	
<input type="text"/>	<input type="text"/>	
Postal address	Postcode	
<input type="text"/>		
Home phone	Email	
<input type="text"/>	<input type="text"/>	
Mobile phone	Work phone	Fax number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship to participant		
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Family member		

Further information

Is the child of Aboriginal or Torres Strait Islander descent? (For statistical purposes only) Yes No

Are one/both the parents from a culturally or linguistically diverse background or community? (For statistical purposes only) Yes No

Health details and related information

Does the participant suffer from the following? (if yes to one or more, please attach details as required)

A current illness (eg. flu) A disability/chronic illness Any allergic condition Asthma (provide asthma plan) Bed wetting

Attention deficit disorder (ADD/ADHD) Behavioural problems Diabetes Epilepsy Sleep walking Skin condition

Other _____

Private health insurance fund	Number	
<input type="text"/>	<input type="text"/>	
Medicare number	Position on card	Valid till
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Swimming ability Strong – 50 metres unaided Average – 25 metres unaided Poor – 10 metres unaided Non-swimmer

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Current medication

Name	Time and dosage – please specify exact time of medication (attach details as required)									
	Breakfast		Lunch		Dinner		Before bed		Other	
	Time	Dose	Time	Dose	Time	Dose	Time	Dose	Time	Dose
eg. Bricanyl	8am	2 puffs	12.30pm	2 puffs	6pm	2 puffs	8pm	2 puffs		

Notes: 1. Scheduled medication must be provided in the original container (as required by legislation). 2. Staff will collect, supervise and register the taking of all medication.

Special requirements and dietary needs

Please identify any special needs or requirements not listed above (eg. diet, wheelchair access etc.)

Has he/she had the Combined Diptheria Tetanus Toxoid booster injection?

Yes No Year _____

Has he/she been immunised against measles?

Yes No Year _____

Privacy statement

The Department of Education and Communities of 6 Figtree Drive, Sydney Olympic Park, NSW 2127 will collect and store the information you voluntarily provide to enable processing of enrolments for the program. The information will be provided to relevant staff and be provided to medical professionals where necessary. You consent to these disclosures. If you have been asked for information regarding Aboriginal and Torres Strait Islander descent and cultural background, this information is voluntary and is being compiled for statistical purposes only. Any information provided by you will be stored on a database that will only be accessed by authorised personnel and is subject to privacy restrictions. The information will only be used for the purpose for which it was collected. Any information provided by you to the Department of Education and Communities can be accessed by you during standard office hours and updated by writing to us or by contacting us on 13 13 02.

I do not wish to receive promotional information about this service offered by Sport and Recreation.

Risk warning and media consent

a) Strike out whichever does not apply:

I agree for my child/ward to attend the Centre and to undertake all activities and/or to participate in the above program. In the case of an emergency, I authorize the Department of Education and Communities, Sport and Recreation staff, where it is impracticable to communicate with me, to arrange for my child/ward to receive such medical or surgical treatment as may be deemed necessary. I also undertake to pay or reimburse costs which may be incurred for medical attention, ambulance transport and drugs while my child/ward is attending the Centre/ enrolled in the program.

I understand that although the Department of Education and Communities, Sport and Recreation and its service providers attempt to minimise any risk of personal injury within practical boundaries, accidents do happen and all physical activities carry the risk of personal injury. I acknowledge that there is an inherent risk of personal injury in physical activities that will be undertaken at the Centre/as part of the program and I accept that risk.

b) Please tick whichever applies to you

I consent / I do not consent to allow the NSW Government to use any photographs, sound and film recordings taken of my child/my ward at this program for the promotion of NSW Government services and initiatives to the media and to the general public.

Name (print)

Signature

Date

 / /

Returning this form

Please return this form to the coordinator of your Sport and Recreation program.

For more information call

13 13 02 or visit www.dsr.nsw.gov.au

