

Medical and consent form

Child

Participant details

Surname Given names

Address

Postcode

Name of school School year NSW Sport and Recreation customer no.

Date of birth / / Age Male Female

Are you of Aboriginal or Torres Strait Island descent? *(statistical purposes only)* Yes No

Are you or your parents from a Non-English speaking background? *(statistical purposes only)* Yes No

Program details

Program type *(please circle)* School / Holiday / Community / Sporting / Recreation / Other

Program number (if known)

Venue Program dates (from) / / (to) / /

Parent/guardian details

	Mother/guardian	Father/guardian	Guardian/other contact
Full name of parent or guardian	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home phone	<input type="text"/>	<input type="text"/>	<input type="text"/>
Work phone	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mobile	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mobile	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mobile	<input type="text"/>	<input type="text"/>	<input type="text"/>

Special/Dietary needs

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

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

Yes No Year

Has he/she been immunised against measles?

Yes No Year

Swimming ability

Strong – 50 metres unaided Average – 25 metres unaided Poor – 10 metres unaided Non-swimmer *continued over...*

Medical information

Does the participant suffer from any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> Any allergic condition | <input type="checkbox"/> Skin condition | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy, fits or blackouts | <input type="checkbox"/> A disability or chronic illness | <input type="checkbox"/> Asthma (include asthma plan) |
| <input type="checkbox"/> Attention Deficit Disorder (ADD/ADHD) | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> A current illness eg. flu |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Behavioural problems | <input type="checkbox"/> Other |

If yes to one or more, please give details (*attach sheet if required*)

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Medicare number	Position number on Medicare card	Health care card number	Pensioner health benefits card	Pharmaceutical benefits concession card
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Private health insurance fund	Number
<input type="text"/>	<input type="text"/>

Do you have ambulance cover? Yes No

Current medication

	Time and Dosage – Please specify exact time of medication									
	Breakfast		Lunch		Dinner		Before bed		Other	
	Name	Time	Dose	Time	Dose	Time	Dose	Time	Dose	Time
eg. Bricanyl	8am	2 puffs	12.30pm	2 puffs	6pm	2 puffs	8pm	2 puffs		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Notes:

1. Scheduled medication must be provided in the original container (as required by legislation).
2. All medications will be collected and administered by staff, unless notified in writing to the contrary.
3. Staff will supervise and register the taking of all medication.

Risk waiver

Program name	Program date
<input type="text"/>	<input type="text"/>

Venue

I agree to my child's/ward's attendance at the above mentioned program.

In the case of an emergency, I authorise the program 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 enrolled with the program.

I understand that although TSR 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 as part of this program.

Full name of parent or guardian

Signature

Date

Privacy statement

The NSW Department of Tourism, Sport and Recreation of 6 Figtree Drive, Sydney Olympic Park, NSW 2127 will collect and store the information you voluntarily provide to enable processing of enrolments for Centre programs. The information will be provided to instructors of the program and their supervisors, where necessary, and you consent to this disclosure. 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 can be accessed by you during standard office hours and updated by writing to us or by contacting us on 13 13 02.

Media consent

Strike out whichever does not apply.

I agree to allow NSW Sport and Recreation to use my child's/my ward's name and any photographs, sound and film recordings taken of my child/my ward at this program for the promotion of the department's services and initiatives to the media and to the general public.

Full name of parent or guardian

Signature	Date
<input style="width: 100%; height: 30px;" type="text"/>	<input style="width: 100%; height: 30px;" type="text"/>

For more information call

13 13 02

www.dsr.nsw.gov.au

For deaf, hearing or speech impaired people TTY (02) 9006 3701

