Medical & Risk Recognition Form

Confidential Participant Information

PCYC Capricorn Coast

The purpose of this form is to provide a written source of information about individuals who are participating in activities provided by PCYC. It is essential that this form is completed fully, and all relevant information is supplied. This document will be required in the event of an incident or emergency in a remote area and will assist staff to understand any special needs that the participant may have. This information is **confidential,** and access is restricted to program staff, except in cases where harm or loss is likely to occur without disclosure of this information.

Participant Details

Participant Name: _____

Organisation (name of group/school): _____

Gender (please tick): ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age: _____

Address: _____

_____ Post Code: _____

Day time telephone: _____ After hours telephone: _____

Parent/ Legal Guardian or Next of Kin Contact Details

Name: _____ Relationship: _____

Address: _____

Day time telephone: _____ After hours telephone: _____

Email Address: _____

Alternative Contact Details

Name: _____ Relationship: _____

Address: _____

Day time telephone: _____ After hours telephone: _____

Any Special Dietary Requirements

_____

_____

Any Custody Information

_____

_____

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Swimming Ability (please tick)

☐ Unknown ☐ Unable to swim ☐ Poor swimmer ☐ Can swim 50 meters ☐ Can swim over 50 meters

Health and Medical Information

If the need arises, do you give consent to the administration of? (please tick)

☐ Paracetamol ☐ Antihistamines ☐ buprofen (anti-inflammatory)

Has the participant had a Tetanus booster? (please tick) ☐ Yes ☐ No Year of Last Booster: _____

Participants Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Place on Card: ___

The more information that is supplied here, the better we are able to meet the needs of the participant. **We aim to make activities inclusive, not exclusive, while maintaining safety**. Please attach any useful additional information on a separate sheet- particularly regarding a medical condition. Include action plans and schedules for medication from health care professionals.

Does the participant have (or ever had) any of the following conditions? (please tick)

☐ Allergies ☐ Asthma ☐ Back problems ☐ Blood disorder
☐ Diabetes ☐ Drug Reactions ☐ Epilepsy ☐ Heart disorder
☐ Intellectual disability ☐ Joint damage ☐ Learning difficulty ☐ Mental Illness
☐ Muscle damage ☐ Other recent illness ☐ Phobias ☐ Physical/sensory disability
☐ Respiratory problems ☐ Self harmed

If you ticked any of the above, please supply full and complete details (attach extra pages if required).

_____

_____

_____

_____

_____

_____

Participant (always required)	_____ Print name	_____ Signature	_____ Date
Parent/Guardian (if participant is under 18yrs)	_____ Print name	_____ Signature	_____ Date

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Risk Recognition

To be read and signed by the participant, and parent/ guardian if participant is under 18 years.

I/ we hereby certify that all details I have provided on this form are true and correct. I understand and agree that:

- This activity is 100% drug and alcohol free.
- Safety is the highest priority and that behaviour which compromises safety is unacceptable.
- Failure to follow instructions may result in exclusion from the activity and being sent home at my expense and that no refund will be provided.

Please tick.

☐ I/ we the undersigned being the participant/ parent/ legal guardian of the above-named participant, acknowledge that all activities entered into by myself/ my son/ my daughter/ my ward contain an element of risk and I/ my son/ my daughter/ my ward must take reasonable care whilst participating in activities.

☐ I/ we understand that activities may include running, jumping, water, swimming, climbing, ascending/ descending ropes, use of specialised adventure equipment and may take place in a rural, remote or natural environment. I/ we also understand some activities are located off site and transportation (by PCYC) may be required.

☐ I have read and understood the participant equipment list and will ensure that myself/ my son/ my daughter/ my ward attends with all the required items on the equipment list.

☐ I/ we further authorise PCYC to obtain all necessary medical treatment which may be required by me/ my son/ my daughter/ my ward including anaesthetic or surgical attention which may be prescribed by an appropriately qualified medical practitioner. I/we acknowledge that the costs of any such treatment, including evacuation and transport shall be my/ the participants responsibility solely.

☐ I/ we allow photographs to be taken of my child and give permission for these to be used for advertising purposes seen fit by PCYC including online media such as Facebook.

☐ I/ we will not allow my son/ my daughter/ my ward to attend camp if unwell, displaying any symptoms of COVID-19, suspect a family member may have come in contact with or been infected with COVID-19 or have been advised by health authorities to self-isolate.

☐ I/ we understand that in the event that my son/ my daughter/ my ward begins showing symptoms of COVID-19 during their stay at PCYC Capricorn Coast they may be isolated from the rest of the group and unable to participate in activities. I/ we understand that risk mitigation measures will be actioned as appropriate following Queensland Health advice.

Participant (always required)	_____ Print name	_____ Signature	_____ Date
Parent/Guardian (if participant is under 18yrs)	_____ Print name	_____ Signature	_____ Date

If you require additional information or there are changes to the participants health prior to the program, contact PCYC Capricorn Coast on (07) 4930 2022.