Džiugo Tuntas

PERSONAL INFORMATION RECORD

(Please fill in the details with dark coloured ink)

Registration Number: ☐☐☐☐☐☐☐

Event: ______________________ **Date/s of Event:** ______________________

NAME: Surname: …………………… Given / Preferred Name: ……………………

HOME ADDRESS: …………………… Email: ……………………

Suburb: …………………… Postcode: …………… Telephone No. ……………………

PERSONAL:
Date of Birth: …………………… Age at Activity: …………… Gender: Male ☐ Female ☐

Medicare No: …………………… Ancillary Benefits Cover: Yes ☑ No ☐

Family sequence No. …………… Medicare Card expiry date: ………/……/……… Ambulance Ins Number ……………

Private Health Insurer: …………………… Private Health Ins Number ……………………

GROUP DETAILS SECTION …………… GROUP …………… DISTRICT …………… REGION ……………

EMERGENCY USE: Details of the Parents/Guardians where they can be contacted during the activity

NAME: …………………… Relationship: ……………………

ADDRESS: ……………………

Suburb: …………………… Mother's Mobile: …………… Home: ……………

Postcode: …………………… Father's Mobile: …………… Business: ……………

In an emergency, if we cannot contact you, whom else can we contact? Name & Relationship: …………… Phone: ……………

HEALTH STATEMENT

If the participant suffers from any chronic or recurrent ailment, allergy or physical incapacity, it should be disclosed so that we are aware of the fact

A.	Does the participant suffer from any physical or other disabilities or ailments?	☐ Yes / ☐ No	If yes, please specify: ……………
B.	Does the participant suffer from		Explanation/Medication:
	Asthma? …………… ☐ Severe / ☐ Mild	☐ Yes / ☐ No	……………
	Diabetes?…………… ☐ Type 1 / ☐ Type 2	☐ Yes / ☐ No	……………
	Epilepsy?…………… ☐ Severe / ☐ Mild	☐ Yes / ☐ No	……………
	Dizzy Spells or Black outs? ……………	☐ Yes / ☐ No	……………
	Bed Wetting? ……………	☐ Yes / ☐ No	……………
	Sleep Walking? ……………	☐ Yes / ☐ No	……………
	Travel Sickness? ……………	☐ Yes / ☐ No	……………
	Migraine Headache? ……………	☐ Yes / ☐ No	……………
C.	Does the participant have any known Allergies? ie Penicillin, bee sting, bites, egg, hay fever, other food, drug or other environmentally related allergy.	☐ Yes / ☐ No	If yes, please specify: ……………
D.	Does the participant have any Medications on this activity? ie Injection/tablet/capsule Penicillin, Insulin, Ventolin, Epipen®, other drugs	☐ Yes / ☐ No	Name of Drug: …………… Dosage: …………… Reason or Cause …………… How Often Administered: …………… Administered by Whom ……………

In the case of a Youth Member, please hand the medication—CLEARLY labelled with the child's name & dosage instructions—to the Leader in Charge of the Youth Member

E. Is there any further information you consider to be important and about which we have not asked above and of which we should be aware (including **special dietary requirements** : ☐ Yes / ☐ No If Yes, please specify

F. Analgesics : In the event of your child requiring the administration of an analgesic (eg. Panadol),, do you **HEREBY CONSENT** to your child being given the recommended child dosage of Paracetamol or Panadol?
☐ Yes / ☐ No **If YES, please sign here:**……………………

G.	**Details of last Anti-Tetanus injection:**	Year of Original Injection		Year of last booster injection	

I hereby **Authorise** the Leader in Charge of the above activity, in circumstances where it is not possible or it is impracticable to communicate with me, to seek for my child, such Surgical, Medical or Dental treatment as a qualified Surgeon, Medical or Dental Practitioner may consider to be necessary (including the transfusion of blood) and I hereby **Consent** to such treatment. **I have read and understand the Privacy Notice overleaf.**

Date : ______________ **Signed:** ______________________ **(Parent / Guardian)**

This form is to be filled out by participant if over 18 years old, or by Parent/Guardian, taken to the event or handed to the Leader in Charge before you leave.

PLEASE SEE OVER PAGE FOR PRIVACY NOTICE