PAPSDA PATHFINDER CLUB 2011

Health Profile

(This profile is designed to assist in the care of all participants, including adults, in events/activities. One form must be completed for each participant.)

Name: **Medic Alert No:**

1. Please tick if you have one of the following:

Migraine	☐	Epilepsy	☐	Asthma	☐
Diabetes	☐	Travel Sickness	☐	Fits of any type	☐
Nose bleeds	☐	Heart Condition	☐	Dizzy spells	☐
Colour blindness	☐	Other (please specify)	______________		

For Overnight events

Sleepwalking ☐ Bed Wetting ☐

2. Are you currently taking any medication? Yes ☐ No ☐

If YES, please state: Ailment/s

Name of Medication/s:

Dosage and time/s to be taken:

Other Treatment:

3. Have you had any major injuries (breaks or strains) or illness (glandular fever etc) in the last 6 months that may limit your full participation in any activities?

Yes ☐ No ☐

4. Are you allergic to any of the following?

	YES	NO	PLEASE SPECIFY
Prescription medication			
Food			
Insect bites/stings			
Other allergies			
What treatment is required?			

5. When was your/your child's last tetanus injection?

6. Outline any dietary requirements

A COPY OF THIS FORM MUST BE TAKEN ON THE EVENT. A COPY SHOULD BE RETAINED BY THE CHURCH OFFICE.

7. What pain/flu medication may your child be given if necessary?

8. To the best of your knowledge, have you/your child been in contact with any contagious or infectious diseases in the last four weeks?

Yes ☐ No ☐

If YES, please give brief details.

9. Is there any information the staff should know to ensure the physical and emotional safety of you/your child? (For example for cultural practices; disability; anxiety about heights/darkness/small spaces; pregnancy; behaviour or emotional problems).

Yes ☐ No ☐

I also agree that if prescription medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labeled, securely fastened and handed to the designated adult with instructions on its administration.

I will inform the appropriate leader as soon as possible of any changes in the medical, dental, or surgical treatment, including anesthetic or blood transfusion, as considered necessary by the medical authorities present.

Any medical costs not covered by ACC or a community services card will be paid by me.

If my child is involved in a serious disciplinary problem, including the use of illegal substances and/or alcohol, or actions that threaten the safety of others, he/she will be sent home at my expense.

Print Name: ______________________________

Signed: ______________________________
(to be read and signed by adult participant or parent/caregiver of child participant)

Date: ______________________________

A COPY OF THIS FORM MUST BE TAKEN ON THE EVENT. A COPY SHOULD BE RETAINED BY THE CHURCH OFFICE