

60-ЛІТТЯ УКРАЇНСЬКОЇ МОЛОДІ



КРАЙОВИЙ ТАБІР 2007-2008



Medical Information Form

Ця інформація зібрана для планування та організування. В разі потреби, Ваші деталі будуть передані до тих осіб котрі провадять даної імпрези або табір. Ця інформація буде забезпечена, але Ви можете мати доступ до неї, коли Вам потрібно.

This information is collected for the purpose of planning and organising activities for all participants. It will be disclosed as appropriate to those conducting activities. We ask your assistance in updating this information as necessary. This information will be kept securely and may be accessed upon request.

Просимо виповнити цю анкету з Вашими даними та медичними інформаціями, щоб ми могли повідомити лікарів в разі потреби.

In order for us to administer appropriate Duty of Care to each participant, the organisers need to ensure that information relating to your medical welfare is maintained during any event.

Personal Details

Child's Full Name _____

Date of Birth _____ Age _____

Program Participating in: _____

Parent's/ Guardian Full Name _____

Address _____

Postcode _____

Medicare Number _____ Expiry Date _____ Ref. No _____

Medical/ Hospital Insurance Fund _____ Contribution No _____

Emergency Contact

Name _____ Relationship _____

Emergency Telephone: After Hours _____

Business Hours _____

Name / Address / Telephone of Family Doctor _____

Medical History

Please tick if your child suffers any of the following:

- | | | | |
|---------------------------------------|---|--|-------------------------------------|
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Fits of any type | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Asthma | <input type="checkbox"/> Black outs |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Travel Sickness | | |
| <input type="checkbox"/> Other | Please specify _____ | | |

Please attach Management Plan as required for any of the above

Allergies to:

Penicillin Any food Other Drugs Other Allergies

Please specify _____

What special care is recommended? _____

Tetanus Immunisation

Last tetanus immunization was

If over ten years since last immunization, please tick if booster is to be arranged by parents before the camp

Booster date

Tablets and Medicines

1. Is your child presently taking tablets and/or medicine? YES/NO

If YES, please state name of medication, dosage etc _____

2. All medicines, must be handed to the first aid leader on arrival, with your child's name, the dose to be taken and when it should be taken. (These will be kept in the first aid center and distributed as required)

Dietary Requirements

Are there any special dietary requirements? YES/NO

If YES, please specify _____

Previous Experience

Is this the first time your child has been away from home? YES/NO

Consent to Medical Attention

I authorize the leaders in charge of the camp activities / excursions / event, where it is impracticable to communicate with me, to the child receiving such medical or surgical treatment as may be deemed necessary.

В разі потреби, я даю команді/проводі табору/імпрези повне право шукати будь яку потрібну медичну допомогу.

I declare that the information provided on this form is complete and correct
Всі подані інформації на цьому анкеті є правельні й точно подані.

Signed: Підпису:

Батько / легальний опікун
Parent / Legal Guardian:

Дата
Date

Note: Please ensure that you have completed all relevant information and return this form to the Camp Administration together with your Camp registration form.

I understand that it is my responsibility to notify the Camp Administration of any changes to these details.