

Section One: General Information

Full Name: _____ Medicare no: _____ Sex: **Male / Female**

Course Type: Stage **1 / 2 / 3** (Please circle) Dates of Course: From _____ To _____

Age: _____ Date of Birth: _____ Private Health Fund: _____ Ambulance Subscriber? **Yes / No**

Home address: _____ Post Code: _____

Emergency Contact Person (1) _____ (Relationship) _____

Phone (work) _____ Phone (home) _____ Mobile _____

Emergency Contact Person (2) _____ (Relationship) _____

Phone (work) _____ Phone (home) _____ Mobile _____

1) Does your child have any allergies? *These may include food or food additives, insect bites, medications, plants or pollens, detergents, cleaning agents or others. If you answered yes, complete Section 3 of this form* **Yes / No**

2) Asthma?: *If yes complete Section 2 - Asthma Management Form.* **Yes / No**

3) Is your child on any prescribed drugs? **Yes / No**
If yes: Condition _____ Drug name _____ Dosage _____ When _____

4) Diabetes: *If yes, please attach separate details of condition. Include history, normal blood sugar levels for different activities, insulin dependency and frequency of injections, dietary requirements, common signs and symptoms in lead up to hypoglycaemia and hyperglycaemia and contact phone number of treating doctor. Wollangarra requires diabetics to bring their own extra food, two glucometers, and an emergency glucose injection kit.* **Yes / No**

5) Epilepsy: *If yes, please supply details of condition in terms of lead up symptoms, frequency, type, medication and contact phone number of treating doctor.* **Yes / No**

6) Has your child ever suffered any neck, shoulder, back hip, knee or ankle injury? If yes, please supply details of injury (indicate left or right), treatment and current condition: **Yes / No**
If yes, please supply details. _____

7) Has your child suffered from migraines or headaches? If yes, please say which, and supply details of triggers, symptoms and treatment. **Yes / No**
If yes, please supply details. _____

8) Circle and provide details if your child suffers from: vertigo (i.e. feels uncomfortable or sick on elevators/escalators/near cliff edges); sleep walking; emotional or behavioural disorders; any other physical disabilities or disorders (e.g. back problems: poor eyesight, compromised hearing, touch or smell) **Yes / No**
If yes, please supply details. _____

9) Has your child suffered any recent illnesses or injuries not covered in an earlier question, or undergone surgery recently? **Yes / No**
If yes, please supply details. _____

10) Can they swim 50 metres without stopping? no [] with a struggle [] comfortably [] strongly []

11) The year of my child's last tetanus immunisation was _____ (*Must be within the last 10 years*)

12) Does your child have any special dietary requirements? _____

13) I **do / do not** authorise my child to be given paracetamol pain relievers (such as Panadol), ibuprofen anti-inflammatories (such as Neurofen), antihistamines (such as Phenergan) or Aspirin as deemed necessary by Wollangarra Wilderness First Aid trained staff.

In the event of any illness or injury, I authorise the obtaining, on my behalf, such medical assistance as my child may require. I declare that my child's tetanus immunisation is current. I agree to cover any medical costs that may arise, including ambulance costs. I have declared all the information that has been required.

Parent/Guardian Signature: _____ Print name: _____ Date: _____

Section Two: Asthma Management Form

Seek the advice of the doctor of your asthmatic child, if necessary, when completing this form.

- 1) Has your child been admitted to hospital due to asthma in the past 12 months? **Yes / No**
- 2) Has your child been on oral cortisone within the past 12 months (eg. Prednisolone, Cortisone, Prednisone, Betamethasone, etc)? *If yes, please state or circle.* **Yes / No**
- 3) Has your child suffered severe asthma attacks requiring hospitalisation? *If so, when was the last?* **Yes / No**
- 4) What are the student's usual symptoms of asthma (Please tick)?
Wheezing Tightness in chest Coughing Difficulty in breathing Other (please describe)

- 5) Is your child on preventers? *If yes, supply details.* **Yes / No**
- 6) Usual asthma management plan followed by your child: _____

- 7) Medication and treatment to be used during worsening asthma: _____

- 8) Medication and treatment to be used during crisis situations: _____

- 9) List any known trigger factor(s) experienced by your child _____

- 10) If known, please complete the following Peak Flow Readings:
Best: _____ **Critical:** _____ **(Bring your own peak flow meter)**

Section Three : Allergy Reaction Management Form

- 1) To what is your child allergic? _____
- 2) What are the signs and symptoms of the allergic reaction? _____

- 3) Has your child at any time in the past suffered from:
[] Localised reaction (any rash, itching, swelling at the site the toxin has entered)
[] Systemic reaction (any rash, itching, swelling away from the site where the toxin has entered)
[] Anaphylactic reaction (severe breathing problems, swelling of the body, emergency situation)
- 4) What medication does your child take to **prevent** allergic reaction? _____
- 5) What treatment is followed for your child if an allergic reaction occurs? _____

The information on this form is true to the best of my knowledge.

Signature: _____ **Date:** _____

Print name: _____