Medical and Safety Information

The following information is important for the care of your child whilst attending an Optimum Experiences program. All information is held in confidence and will only be used in reference to the camp which your child is attending. This form must be completed by a Parent or Guardian.

How to submit the form. Download the form and open the PDF in Adobe Acrobat Reader **(Download Acrobat Reader)**. Fill out your information and save the file. Email the completed PDF to **your Schools' Outdoor Ed coordinator**

General Information:

Students Name: _____

Address: _____

City: _____ State:_____ Zip: _____

Phone:_____ Business / Mobile:_____

Medical Fund: _____Number: _____

Medicare Number: _____ Age on camp: _____ ☐ Male or ☐ Female

☐ School ☐ Group

Medical Information:

Is your child under any treatment for any illness or condition that we need to be aware of. **Please indicate any current medications.** _____

_____

Asthma: Please Check ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Medication Details: _____

If moderate or severe has been ticked please complete Asthma Management Form.

Allergies: Please Check ☐ **Food** ☐ **Drugs** ☐ **Insects**

Other: _____

If moderate or severe has been checked please complete Allergenic Reaction Management Form.

Allergies: Please Check ☐ **Vegetarian** ☐ **Vegan** ☐ **HALAL** ☐ **No Dairy Products**

Other: _____

Injuries, illnesses or disabilities that have a history and need to be brought to our attention:

_____

Swimming Ability: Please Check ☐ **Weak/Beginner** ☐ **50 meters** ☐ **100 meters** ☐ **200 meters**

I, _____ acknowledge that my child is participating in activities that may mean an increased risk of injury. Optimum Experiences will exercise due care and attention for the above child; however, in the event of any accident or illness (excluding negligence), I understand that Optimum Experiences shall not be held responsible.

I authorise the Program Director and Leading - teacher in charge on my behalf where it is impossible to communicate with me, to consent to my child receiving such medical assistance as may be deemed necessary, including transport by ambulance. I also undertake to pay medical fees and/or cost of medication which may be incurred while my child is at camp.

Signed: _____ **Date:** _____

***Please attach to this form any other information that you regard as necessary and relevant to your child.**

Asthma Management Form **Seek the advice of the astmatic's dotor if necessary when completeing this form.** (Please Print all responses)

Name: _____

1. Usual maintenance medical program followed by the asthmatic: _____

2. Peak Flow Readings Best_____ Critical _____(Bring Own Peak Flow Meter)

3. Medication and treatment regime to be used during an emergency asthma attack

_____

4. List any known asthma trigger factor experienced by the asthmatic:

_____

Key Questions:

5. Has the asthmatic been admitted to hospital due to asthma in the past 12 months?	☐ Yes	☐ No
6. Has the asthmatic been on oral cortisone for asthma within the past 12 months (eg. Prednisone, Cortisone, etc)?	☐ Yes	☐ No
7. Has the asthmatic suffered sudden severe asthma attacks requiring hospitalisation?	☐ Yes	☐ No
8. Does the asthmatic require the use of a nebulising pump as a part of their regular or emergency Asthma Treatment?	☐ Yes	☐ No

NOTE: The Participant must supply the appropriate medication which has been prescribed by their Medical Officer.
I declare that the information provided on this form is complete and correct. I give permission for Optimum Experiences to pass this information to a third party [e.g. Camp Administration, Doctor, and Hospital...] to facilitate the medical treatment of my child.

Parents Name:_____ **Signature:** _____ **Date:** _____

Allergenic Reaction Management Form **Seek the advice of the astmatic's dotor if necessary when completeing this form.** (Please Print all responses)

A DOUBLE DOSE OF *ALL* MEDICATION REQUIRED FOR THE SUFFERER'S ALLERGIC REACTION, *MUST* BE BROUGHT ON THE COURSE BY THE PARTICIPANT, AND NOTED ON THEIR MEDICAL FORM.

Name: _____

1. What is the person allergic to? _____

2. What are signs and symptoms of the person's reaction?

_____

3. Historically, has the person suffered from?

- ☐ a) a localised reaction (rash, itching, swelling at the site the poison/irritant enters),
- ☐ b) a systemic reaction (rash, itching, swelling away from the site that poison/irritant enters),
- ☐ c) an anaphylactic reaction (severe breathing problem, total body swell, emergency situation).

4. What medication does the person take (if any) for their allergic reaction?

_____

5. What treatment is followed by the person during allergic reaction?

_____

Key Questions:

6.Does the person suffer a systemic or an anaphylactic reaction (see question 3 for definition), to their allergy?	☐ Yes	☐ No
7. Is there a history, in the person's family, of anaphylaxis?	☐ Yes	☐ No
8. Has the above named sufferer been admitted to hospital due to an allergic reaction?	☐ Yes	☐ No
8. Does the person take adrenaline (Epi-pen), when suffering an allergic reaction ?	☐ Yes	☐ No

NOTE: The Participant must supply the appropriate medication which has been prescribed by their Doctor.
I declare that the information provided on this form is complete and correct. I further declare that if my child's emergency management requires use of an Epipen, I give permission for Optimum Experiences staff to administer. I give permission to pass this information to a third party [e.g. Camp Administration, Doctor, and Hospital....] to facilitate the medical treatment of my child.

Parents Name:_____ **Signature:** _____ **Date:** _____