

# Medical and consent form – Child

Complete form in BLOCK LETTERS

## Participant details

First name	Last name	<input type="checkbox"/> Male	Date of birth
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Female	<input type="text"/> / <input type="text"/> / <input type="text"/>
School name	Year group		
<input type="text"/>	<input type="text"/>		
Postal address		Postcode	
<input type="text"/>		<input type="text"/>	

## Program details

Program number (if known)	Centre name	Date from	Date to
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

## Parent/guardian contact details

First name	Last name	
<input type="text"/>	<input type="text"/>	
Postal address		
<input type="text"/>		
Postcode		
<input type="text"/>	<input type="text"/>	
Home phone	Email	
<input type="text"/>	<input type="text"/>	
Mobile phone	Work phone	Fax number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship to participant <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Family member		

## Allergies and special diets

Sport and Recreation endeavours to provide safe, healthy meals to all clients, including those with special dietary needs. Those at risk from food related anaphylaxis require the highest level of care. It is important that we receive information regarding food related allergies even if your child is attending a self-catered program. This form MUST be received by Sport and Recreation at least two weeks before the program commences.

If your child has a special dietary need please provide information using the categories below.

**1. Food related anaphylaxis diagnosed by a doctor.** (An anaphylaxis action plan and at least one adrenaline auto-injector MUST be provided).

Please indicate the item/s your child CANNOT eat

Peanuts  Tree nuts  Egg  Wheat  Sesame  Crustaceans  Fish  Milk  Soy  Sulphites (specify below)

Other/further information \_\_\_\_\_

**2. Allergy or intolerance.** (Particular foods can cause discomfort and illness, but are not life threatening).

Please indicate the item/s below your child CANNOT eat

Peanuts  Tree nuts  Egg  Wheat  Sesame  Crustaceans  Fish  Milk  Soy  Gluten  Lactose/Dairy  
 Yeast  Food Additives (specify below)  Sulphites (specify below)

Other/further information \_\_\_\_\_

**3. Aversion/religious beliefs/lifestyle choice.** (You or your child have made a decision not to eat these foods, or to eat certain types of foods).

Please indicate your child's special diet

Vegan  Vegetarian  No red meat  No beef  Halal  Kosher

Other/further information \_\_\_\_\_

**4. Non-food related allergy.** (A doctor has diagnosed my child with a non-food related allergy).

Please indicate your child's non-food related allergy

Insect bite/sting (specify below)  Medication (specify below)  Other (specify below)

Other/further information \_\_\_\_\_

Has he/she been hospitalised with a severe allergic reaction  Yes  No

Has he/she been prescribed an adrenaline auto injector (EpiPen® or AnaPen®)  Yes  No

Does he/she have an ASCIA Action Plan for anaphylaxis  Yes  No

**Children diagnosed with anaphylaxis must have an ASCIA Action Plan and at least one auto-injector.**

(Please attach and return with the form).

## Health details and related information

Does the participant suffer from the following? (*Please attach details as required*).

- A current illness (e.g. flu)  A disability/chronic illness  Asthma (provide asthma plan)  Bed wetting  
 Attention deficit disorder (ADD/ADHD)  Behavioural problems  Diabetes  Epilepsy  Sleep walking  Skin condition  
 Other \_\_\_\_\_

Has he/she had the Combined Diphtheria Tetanus Toxoid booster injection?  Yes  No Year \_\_\_\_\_

Has he/she been immunised against measles?  Yes  No Year \_\_\_\_\_

Private health insurance fund \_\_\_\_\_ Number \_\_\_\_\_

Medicare number \_\_\_\_\_ Position on card \_\_\_\_\_ Valid till \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Swimming ability  Strong – 50 metres unaided  Average – 25 metres unaided  Poor – 10 metres unaided  Non-swimmer

## Current medication

Name	Time and dosage – please specify exact time of medication (attach details as required)									
	Breakfast		Lunch		Dinner		Before bed		Other	
	Time	Dose	Time	Dose	Time	Dose	Time	Dose	Time	Dose
e.g. Bricanyl	8am	2 puffs	12.30pm	2 puffs	6pm	2 puffs	8pm	2 puffs		

- Notes: 1. Scheduled medication must be provided in the original container (as required by legislation).  
2. Staff will collect, supervise and register the taking of all medication.  
3. Participants at risk of anaphylaxis need to provide at least one auto injector (e.g. EpiPens®/AnaPens®).

## Optional information

Is the child of Aboriginal or Torres Strait Islander descent? (For statistical purposes only)  Yes  No

Are one/both the parents from a culturally or linguistically diverse background or community? (For statistical purposes only)  Yes  No

## Privacy statement

The Department of Education and Communities of 6B Figtree Drive, Sydney Olympic Park, NSW 2127 will collect and store the information you voluntarily provide to enable processing of enrolments for the program. The information will be provided to relevant staff and be provided to medical professionals where necessary. You consent to these disclosures. If you have been asked for information regarding Aboriginal and Torres Strait Islander descent and cultural background, this information is voluntary and is being compiled for statistical purposes only. Any information provided by you will be stored on a database that will only be accessed by authorised personnel and is subject to privacy restrictions. The information will only be used for the purpose for which it was collected. Any information provided by you to the Department of Education and Communities can be accessed by you during standard office hours and updated by writing to us or by contacting us on 13 13 02.

I do not wish to receive promotional information about this service offered by Sport and Recreation.

## Risk warning and media consent

a) Strike out whichever does not apply:

I agree for my child/ward to attend the Centre and to undertake all activities and/or to participate in the above program. In the case of an emergency, I authorise the Department of Education and Communities, Sport and Recreation staff, where it is impracticable to communicate with me, to arrange for my child/ward to receive such medical or surgical treatment as may be deemed necessary. I also undertake to pay or reimburse costs which may be incurred for medical attention, ambulance transport and drugs while my child/ward is attending the Centre/enrolled in the program.

I understand that although the Department of Education and Communities, Sport and Recreation and its service providers attempt to minimise any risk of personal injury within practical boundaries, accidents do happen and all physical activities carry the risk of personal injury. I acknowledge that there is an inherent risk of personal injury in physical activities that will be undertaken at the Centre/as part of the program and I accept that risk.

b) Please tick whichever applies to you

I consent /  I do not consent to allow the NSW Government to use any photographs, sound and film recordings taken of my child/my ward at this program for the promotion of NSW Government services and initiatives to the media and to the general public.

Name (print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Returning this form

Please return this form to the coordinator of your Sport and Recreation program.

For more information call

**13 13 02** or visit **www.dsr.nsw.gov.au**

April 2013



Office of  
Communities  
Sport & Recreation