MEDICAL HISTORY

Name: ____

Address: ____

____

Phone: Home: (____) ________________Mobile: _____________________

Email: ____

Date of birth: ____/____/_____

1st Person to contact in an emergency: ____

Relationship to JYF/ YF/ Adult: ______________________________________

Emergency contact Numbers: (H) ________________ (M) ________________________

email: ____

2nd Person to contact in an emergency: ____

Relationship to JYF/ YF/ Adult: ______________________________________

Emergency contact Numbers: (H) ________________ (M) ________________________

email: ____

Medicare Number: ______________________ Do you have Ambulance cover? Yes /NO

Do you have private health cover? YES / NO, If yes, health care provider and number?

____

Your family doctors name: _________________________contact number: ______________

Does your child have, or have they ever had, any of the following? (either Y or N)

[ ] Fainting spells or dizziness

[ ] Epilepsy

[ ] Stomach trouble or ulcers

[ ] Concussion or head injury

[ ] Breathing disorder / asthma

[ ] Chronic pain

[ ] Diabetes

[ ] Heart Disease / angina / ^BP

[ ] Skin disease / problems

[ ] Blood disorder

[ ] Arthritis or rheumatism

[ ] Dislocation/s

[ ] Bee / wasp sting reaction

[ ] Ear disorders

When was the last episode? ____

If you have responded positively to any of the above, what treatment was given and what medication does your child require?:____

____

____

Any known allergies / hypersensitivity to foods, medication, plants, Tetanus antitoxin or serum, bees or other insects or animals? YES / NO

If Yes, please indicate the agent, the type of reaction and the treatment given:

____

____

Any other medical conditions or health concerns that would limit activity or may require special care during camp (for example, psychological/behavioral/emotional, migraines, orthodontic, orthopedic, visual, spinal problems):

____

____

____

____

Please describe any other information about the camper that you think the camp leaders should know about (including sleep disturbances such as bedwetting, nightmares, or sleep walking) to assure that the camper has a safe and happy camp experience:

____

____

____

Date of last Tetanus immunization (if known) ________________

Are you currently taking any medication? YES / NO

If yes, attendees under the age of 18 will be sent a medication authorisation form to complete and return to the camp organiser. All medications will be held by an adult throughout the duration of the camp.

Please circle the following over-the-counter medications that camp leaders may give to your child:

paracetemol / antacid /anti-diarrheal /aspirin / antihistamine / ibuprofen /

All of the above / other ______________________________________.

Parent / Guardian Name: ______________________________

Signature: ____ Date: _____________

© The Religious Society of Friends (Quakers) in Australia Incorporated
Registered contact address: PO Box 4035 Carlingford North NSW 2118
Phone: 0423 308 550