

Protecting Your Privacy

Protecting your privacy is important to us. The information we seek allows us to manage risk, provide reasonable care and administer your involvement in our program. We are careful to keep your information confidential, and provide it only to those agents acting on behalf of the organisation who need it to enable them to perform their agreed activities (e.g. the First-Aider-In-Charge). You are welcome to contact our office in relation to issues regarding your personal information and for a copy of our Privacy Policy.

We only ask for information that is necessary for the purposes outlined in this statement. In some circumstances, if you don't provide us with all requested information, you could miss the opportunity to be involved in our program.

Program & Date: _____

Personal Contact Details

Family Surname(s) _____

Address _____

Suburb _____ Postcode _____ Phone () _____

Parent(s)/Guardian(s) Given Name(s)	Preferred Name (if different)	Gender	Date of Birth
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____

Please provide the following information for each child:

Given Name(s)	Preferred Name (if different)	Gender	Date of Birth	School Year
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____

Do you consent to appropriate use by us of photographs taken on the program that include your family e.g., inclusion in our Facebook page, placement on our web page? Yes No

Program Preparation Details

Dietary Requirements:

Does any member of your family have any special dietary requirements? Yes No

If so, please list them: (We will endeavour to meet these requirements, and will contact you if necessary)

Please provide a rating for each member of your family in terms of swimming ability (either Non Swimmer, Fair or Good Swimmer)

Safety and Care Details

In the event of an emergency, please list phone numbers where a friend or relative may be contacted during the course of the program.

Name	Relationship	Phone Number
_____	_____	_____

Information on Relevant Conditions

Are there any conditions which require special attention that we should know about, e.g. hearing or sight impairment, ADD or ADHD, behaviour issues, formal counselling situations, or any other? *Please list below:*

Medical Information

 Please give details of your family's medical insurance if applicable

Insurance Provider: _____ Membership Number: _____
Medicare Number: _____ Numbers of people on Medicare Card: ___ Expiry Date: ___
Do you have ambulance cover? Yes No Health Care Card Number (if applicable): _____

Important: Please note that in regards to non-prescription medications such as paracetamol (e.g. Panadol), it is our policy that leader team members do not provide medications.

Will family members need to take any tablets or other medication during the course of the program? Yes No

If yes, please give details and indicate family member: _____

Has a family member been taken off medication recently? If yes, please give details? Yes No

What are the years of your last tetanus injections? _____

Yes No

Have family members previously broken/fractured any bones? If Yes, please give details and indicate which family member:

Specific Medical Conditions Please indicate in the relevant columns if any members of your family have had any of the following, providing additional details if necessary. Be sure to provide the name of the family member concerned in each case.

Condition	In the Past	Present	Details: e.g. severity, last injection, treatment	Condition	In the Past	Present	Details: e.g. severity, last injection, treatment
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>		Hypo activity	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>		Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	
Fits/Convulsion	<input type="checkbox"/>	<input type="checkbox"/>		Allergy – foods	<input type="checkbox"/>	<input type="checkbox"/>	
Faint/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>		Allergy – animal	<input type="checkbox"/>	<input type="checkbox"/>	
Glandular Fever	<input type="checkbox"/>	<input type="checkbox"/>		Allergy – other	<input type="checkbox"/>	<input type="checkbox"/>	

Particular Activities

In attending the program, your family consents to participation in a range of general sporting and recreational activities. If potentially risky activities of a specific nature are included, the Team Leader will inform you of these.

Are there any specific activities that you do not wish members of your family to participate in? Yes No

If yes, please specify:

Your Agreement with the Organisation

I am aware in signing this document in regards to my family's participation in this program that certain elements of the program could be physically and emotionally demanding. Furthermore, I understand that certain inherent risks and dangers exist in the activities in which my family will be participating. I acknowledge that while the organisation and its leaders will make every reasonable effort to minimise exposure to known risks, all hazards and dangers associated with these activities cannot be foreseen or may be beyond the control of the organisation, its leaders and staff. In the event of any emergency where my nominated contact people are unavailable:

1. I authorise the leaders to obtain medical advice and/or assistance which they deem necessary.
2. I further authorise qualified practitioners to administer anaesthetic if required.
3. I accept all operation, blood transfusion and/or anaesthetic risks involved in the event that such procedures are deemed necessary.
4. I accept the responsibility for payment and agree to pay medical, transport and any other related expenses.
5. I confirm that the information contained in this document is true and correct.
6. I agree to inform the leader of any change to these details.

Name of Caregiver

Signature of Caregiver

Date