

# Participant Medical Form

**Confidential**



The purpose of this form is to help us adequately prepare for your child's program. This information is confidential and Participants will not normally be excluded for medical reasons.

**PARTICIPANT NAME:** \_\_\_\_\_ **D.O.B:** \_\_\_/\_\_\_/\_\_\_\_\_ **Male**  **Female**

**Parent or Guardian – Primary Emergency Contact:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone:** (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

**Medicare No:**

**Valid to:** \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

<b>MEDICAL HISTORY</b>	Please tick either <b>Yes or No</b> to all Questions		<b>Provide detailed information:</b> How serious is it? What is it? When? Has it fully recovered? Any known triggers? Is it self managed? Anticipated special management?
Asthma	[ ] No	[ ] Yes	If YES, complete the “ <b>Asthma Management Form</b> ”
Allergies	[ ] No	[ ] Yes	If YES, complete the “ <b>Allergy Management Form</b> ”
Diabetes	[ ] No	[ ] Yes	
Epilepsy	[ ] No	[ ] Yes	
Joint/muscle/bone problems?	[ ] No	[ ] Yes	
Sight/hearing impairment	[ ] No	[ ] Yes	
Any serious injuries/illness in the last 12 months?	[ ] No	[ ] Yes	
Is your child currently on any medications?	[ ] No	[ ] Yes	<i>Please name the medication and dosage</i>
Any other conditions that may affect participation?	[ ] No	[ ] Yes	<i>Any health, psychological or learning issues that require attention or special care?</i>

<b>DIETARY</b>	[ ] No	[ ] Yes	If vegetarian, does your child eat fish or white meat?
Any special requirements?			

<b>SWIMMING ABILITY</b>	[ ] No	[ ] with a struggle	[ ] Comfortably	[ ] Strongly
My child can swim 50metres				

*Please note: OEG may require, after reviewing this information, that your child visits a doctor to gain approval to participate. This will be determined after this form is received by OEG and in consultation with you*

Office use only:

I declare that the information which I have provided on this form is complete and correct and that I will notify the school if any changes occur. I authorise the teacher or any employee of the Outdoor Education Group who is with my child, to give consent where it is impractical to communicate with me, and agree to my child receiving such medical or surgical treatment as may be deemed necessary. I give permission for OEG to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment of my child. I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per Privacy Policy documented on our website: (oeg.net.au):

Signed: \_\_\_\_\_ (Parent/Guardian) Date: \_\_\_\_\_

**Photograph Consent:** I consent to my child being photographed and/or visual images of my child being taken during activities, for use in OEG publications, on the OEG website, or for publicity purposes without acknowledgment and without being entitled to any remuneration or compensation. *(Please strike out this sentence if you do not agree)*

# Asthma Management Form

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Participant's Name: \_\_\_\_\_

*If necessary, seek the advice of your doctor when completing this form.*

1. Usual maintenance medical program followed by the asthmatic:

\_\_\_\_\_

Preventer medication \_\_\_\_\_ Reliever Medication \_\_\_\_\_

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 factors experienced by the asthmatic:

\_\_\_\_\_

## "KEY QUESTIONS"

5.	Has asthma interfered with participation in normal physical activities within the past 12 months?	YES [ ]	NO [ ]
6.	Has the participant been admitted to hospital due to asthma in the past 12 months?	YES [ ]	NO [ ]
7.	Has the participant been on oral cortisone for asthma within the past 12 months (e.g. Prednisone, Cortisone, etc)?	YES [ ]	NO [ ]
8.	Has the participant suffered sudden severe asthma attacks requiring hospitalisation within the past 12 months?	YES [ ]	NO [ ]
9.	Does the participant require the use of a nebulising pump as a part of your regular or emergency asthma treatment?	YES [ ]	NO [ ]

## IMPORTANT NOTES:

***If any of the "KEY QUESTIONS" 5, 6, 7 or 8 or 9 above are answered "Yes", the decision for the participant to attend rests with their Doctor. A "Fitness to Participate" form must be completed by the Doctor (attached). Please bring this form to the Doctor with you.***

The Fitness to Participate form should be attached to the medical and asthma management forms and returned to school.

I declare that the information provided on this form is complete and correct and that I will notify the school if any changes occur. I further declare that if my child (or myself for adults) is unable to self administer supplied medication, I give permission for trained OEG staff to administer the supplied emergency medication. I give permission for OEG to pass this information to a third party [eg Doctor, Hospital] to facilitate the medical treatment of my child (or myself for adults). I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per Privacy Policy documented on our website: (oeg.net.au)

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Allergenic Reaction Management Form

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If necessary, seek the advice of your doctor when completing this form.

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

**Participant's Name:** \_\_\_\_\_

1. What is the participant allergic to? \_\_\_\_\_

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

3. Historically, has the participant 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 participant take (if any) for their allergic reaction?: \_\_\_\_\_

## "KEY QUESTIONS"

5. Have allergies interfered with participation in normal physical activities within the past 12 months?	YES [ ]	NO [ ]
6. Has the participant been admitted to hospital due to allergies in the past 12 months?	YES [ ]	NO [ ]
7. Has the participant suffered a systemic or an anaphylactic reaction (see question 3 for definition), to their allergy when triggered in the last 10 years?	YES [ ]	NO [ ]
8. Is there a history of anaphylaxis in the person's family?	YES [ ]	NO [ ]
9. Does the person take adrenaline (Epi-pen), when suffering an allergic reaction?	YES [ ]	NO [ ]

## IMPORTANT NOTES:

***If any of the "KEY QUESTIONS" 5, 6, 7 or 8 or 9 above are answered "Yes", the decision for the participant to attend rests with their Doctor. A "Fitness to Participate" form must be completed by the Doctor (attached). Please bring this form to the Doctor with you.***

The Fitness to Participate form should be attached to the medical and asthma management forms and returned to school.

I declare that the information provided on this form is complete and correct. I further declare that if my child (or myself for adults) is unable to self administer supplied medication, I give permission for trained OEG staff to administer the supplied emergency medication. I give permission for OEG to pass this information to a third party [eg Doctor, Hospital ] to facilitate the medical treatment of my child (or myself for adults). I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per Privacy Policy documented on our website: (oeg.net.au).

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Fitness to Participate Form

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School Name: \_\_\_\_\_ Year Level: \_\_\_\_\_

Name of Participant: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Specific Medical Condition: (e.g. Asthma, Allergies) \_\_\_\_\_

### Notes to treating Doctor

This patient is scheduled to participate in an Outdoor Education program and has self-identified a pre-existing medical condition on their medical form.

Outdoor Education programs with OEG are centred in a 'semi-wilderness' setting, meaning that professional medical care may be from 1 to 6 hours away. All programs include regular physical exercise and activities may include bushwalking (with packs), camping, cycling, rock climbing or canoeing. We operate in all weather conditions.

(Should you require any further information on the program, please contact us at (03) 5770 8200 and quote the name of the client organisation and year level listed at the top of this page)

OEG staff hold a Wilderness First Aid qualification (minimum of 7 days training). This training is based on assessing and treating a patient in a remote or wilderness setting (for more information contact [www.wmi.net.au](http://www.wmi.net.au)).

### Doctor to complete:

Based on this information above and the patient's condition, we ask that you decide on this person's suitability to participate in the upcoming program. If approved, please include specific treatment protocols to follow in the event of an emergency.

**Do you approve this participant attending an Outdoor Education program, based on their current medical condition, coupled with the demands of the program?**

Yes                       No

What treatment protocol are you willing to authorize for this patient in the case of a medical emergency, in a remote location (i.e. one or more hours away from medical care)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

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