

Warren Junior Golf

CONSENT AND MEDICAL INFORMATION FORM

2 Day Coaching camp

Please complete this form and either return on the day of the camp or by mail to : Rhonda Connelly, Raby Irrigation, 1366 Carinda Road , Warren, if there are any medical matters that need prior organisation.

Date of your camp (27<sup>th</sup> and 28<sup>th</sup> September 2010)

SURNAME \_\_\_\_\_ PARENT /CARER NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_ Parent's daytime PH no \_\_\_\_\_

ADDRESS \_\_\_\_\_ P/CODE \_\_\_\_\_

Fax No \_\_\_\_\_ Home Ph \_\_\_\_\_

AGE \_\_\_\_\_ DOB \_\_\_\_\_

MEDICAL INFORMATION – IMPORTANT NOTE

- A. Any child attending the camp with an existing medical condition should bring a letter from his/her doctor regarding detailed treatment of the condition. Information regarding severe asthmatics, diabetics, and other urgent conditions should also be brought to the camp.
- B. Medication brought to the camp should be clearly labelled with child's name. Dosage and times. Only medication with the child's name on it will be administered.
- C. A copy of any special diet ordered by a doctor should be sent prior to the camp. Special dietary food should be discussed with the program coordinator.

PLEASE ANSWER THE FOLLOWING QUESTIONS;

- 1. Is she/he in good health? YES / NO
- 2. Does your child suffer from any chronic illness or disability? YES / NO
- 3. Has she / he suffered from an acute illness during the last 4 weeks? YES / NO
- 4. Has she / he been treated by a medical practitioner for an injury during the past 4 weeks? YES / NO

If the answer is yes, please obtain a report from the doctor with instruction regarding further treatment and a certificate stating that the child is fine to attend the camp.

- 5. Is she/he taking any medication at present? YES / NO

Please provide full details or attach instructions from the doctor concerned.

Name Medication	Dosage	Times to be taken	Reason / Condition
_____	_____	_____	_____
_____	_____	_____	_____

Are any of the above medications to be kept with the child at all times or in a refrigerator?

Please indicate which medications

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6. Does he /she suffer from :

- |                   |          |                             |          |
|-------------------|----------|-----------------------------|----------|
| a. Asthma         | YES / NO | d. Epilepsy , or blackouts. | YES / NO |
| b. Skin Condition | YES / NO | e. Sleep Walking            | YES / NO |
| c. Diabetes       | YES / NO | f. Allergic reactions       | YES / NO |

If yes, please give full details of any necessary treatment \_\_\_\_\_

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\*Please attach a current asthma Action Plan for your child

7. Does your child have any allergic reactions to any medications? YES / NO

If yes please give details \_\_\_\_\_

MEDICAL TREATMENT; Your Medicare card number is required in order to receive immediate medical treatment should this be necessary.

Medicare Number: \_\_\_\_\_

Valid until \_\_\_\_\_ Private Health Insurance Fund \_\_\_\_\_

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

PARENT, CARER OR GUARDIAN CONSENT.

\*I agree to my child's attendance at the Warren Junior golf camp and for him/her to participate in all activities organized by the staff and coaches.

\*I have accurately completed the medical forms and in doing so have detailed any illnesses that my child may suffer.

\*In the event of an accident or illness, I authorise the obtaining of medical assistance on my behalf that my child may require. I also undertake to pay any medical fees and /or cost of medicines, which may be incurred while my child is at the camp.

\*I give permission for my son / daughter to be photographed or videoed at the camp.

*I hereby release Warren Junior Golf, and it's coaches, servants and agents against all actions, lawsuits, claims, demands, proceedings, losses, damages, compensation, costs, charges, and any expenses whatsoever in respect of any personal injury of or any infringement disturbance or destruction of any rights of any person including myself and my son /daughter /ward arising directly or indirectly out of the aforementioned administration of medication.*

Please sign below to indicate your agreement to the above conditions.

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Signature of parent, guardian, carer

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Print name of parent, Guardian , Carer