MEDICAL AND RISK RECOGNITION FORM
(CONFIDENTIAL PARTICIPANT INFORMATION)

BORNHOFFEN LEADERSHIP DEVELOPMENT CENTRE PCYC

The purpose of this form is to provide a written source of information about individuals who are participating in activities provided by PCYC. It is essential that this form is completed fully and all relevant information is supplied. This document will be required in the event of an incident or emergency in a remote area and will assist staff to understand any special needs that the participant may have. This information is **confidential** and access is restricted to program staff, except in cases where harm or loss is likely to occur without disclosure of this information.

PARTICIPANT DETAILS

Participant Name: _____

Organisation (name of group / school): _____

Gender (please tick) : ☐Male ☐Female Date of Birth: _____/_____/_____ Age: _____

Address: _____

_____ State: _____ Postcode: _____

Day time telephone: _____ After hours telephone: _____

Participants Medicare Number __ __ __ __ __ __ __ __ __ __ Place on Card ___ Expiry _____

PARENT/LEGAL GUARDIAN CONTACT DETAILS

Name_____ Relationship_____

Address_____

Daytime Telephone_____ After Hours Telephone_____

ALTERNATIVE CONTACT DETAILS

Name_____ Relationship_____

Address_____

Day time telephone_____ After hours telephone_____

ANY CUSTODY INFORMATION

_____

_____

ANY SPECIAL DIETARY REQUIREMENTS

_____

_____

SWIMMING ABILITY (please tick)

☐Unknown ☐Unable to swim ☐Poor swimmer ☐Can swim 50 metres ☐Can swim over 50 metres

PLEASE TURN OVER

BORNHOFFEN PCYC 3510 NERANG MURWILLUMBAH ROAD NATURAL BRIDGE QLD 4211
Office: (07) 5533 6154 Fax: (07) 5533 6189 Email: admin@bornhoffenpcyc.org.au

HEALTH AND MEDICAL INFORMATION

Has the participant had a Tetanus injection? (Please tick) ☐Yes ☐No Year of Last Booster: _____

If the need arises do you give consent to the administration of? (Please tick for Yes or leave blank for No)

☐Paracetamol ☐ Antihistamines ☐Ibuprofen (anti – inflammatory)

CURRENT AND PAST MEDICAL CONDITIONS: The more information that is supplied here, the better we are able to meet the needs of the participant. **We aim to make activities inclusive, not exclusive, while maintaining safety.** Please attach any useful additional information on a separate sheet - particularly regarding a medical condition. Include action plans and schedules for medication from health care professionals.

Does the participant have or ever had any of the following? (please tick for Yes or leave blank for No)

☐Allergies	☐Asthma	☐Back Problems	☐Blood Disorder
☐Diabetes	☐Drug Reactions	☐Epilepsy	☐Heart Disorder
☐Intellectual Disability	☐Joint Damage	☐Learning Difficulty	☐Mental Illness
☐Muscle Damage	☐Other Recent Illness	☐Phobias	☐Self Harmed
☐Physical/Sensory Disability	☐Respiratory Problems		

If you answered yes to any of the above, please supply full and complete details.

Additional information/ sheet attached ☐Yes / ☐No

RISK RECOGNITION

TO BE READ AND SIGNED BY THE PARTICIPANT
ALSO TO BE READ AND SIGNED BY PARENT/GUARDIAN IF PARTICIPANT IS UNDER 18 YEARS

I/we hereby certify that all details I have provided on this form are true and correct. I understand and agree that: (Please Tick)

☐ This activity is 100% drug and alcohol free.

☐ Safety is the highest priority and that behaviour which compromises safety is unacceptable.

☐ Failure to follow instructions may result in exclusion from the activity and being sent home at my expense and that no refund will be provided.

☐ This program is a challenge by choice. I'm participating under my own free will.

☐ I/we the undersigned being the participant/parent/legal guardian of the above-named participant, acknowledge that all activities entered into by myself/my son/my daughter/my ward contain an element of risk and I/my son/my daughter/my ward must take reasonable care whilst participating in activities.

☐ I/we understand that activities may include running, jumping, water, swimming, climbing, ascending/descending ropes, use of specialised adventure equipment and may take place in a rural, remote or natural environment.

☐ I have read and understood the participant equipment list and will ensure that myself/my son/my daughter/my ward attends with all the required items on the Equipment List.

☐ I/we further authorise PCYC to obtain all necessary medical treatment which may be required by me/my son/my daughter/my ward including any anaesthetic or surgical attention which may be prescribed by an appropriately qualified medical practitioner. I/we acknowledge that the costs of any such treatment, including evacuation and transport shall be my/the participant's responsibility solely.

Participant (Always required)	_____ **Print Name**	_____ **Signature**	____/____/_____ **Date**
Parent/Legal Guardian (If participant under 18)	_____ **Print Name**	_____ **Signature**	____/____/_____ **Date**

IF THERE ARE CHANGES TO THE PARTICIPANT'S HEALTH PRIOR TO THE PROGRAM, PLEASE CONTACT US

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