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 / EMERGENCY CONTACT DETAILS

Name: _____ Relationship: _____

Address: _____

Daytime Telephone: _____ After Hours Telephone: _____

Any custody information:_____

_____

ALTERNATIVE CONTACT DETAILS

Name: _____ Relationship: _____

Address: _____

Daytime Telephone: _____ After Hours Telephone: _____

SPECIAL DIETARY REQUIREMENTS

Known food allergens or dietary requirements: _____

_____

_____

Dietary Risk Level (Please tick as appropriate)

- ☐ LEVEL 1 RISK – life threatening allergic reaction / anaphylaxis
- ☐ LEVEL 2 RISK – medical condition e.g. coeliac, mild to moderate allergic reaction to foods
- ☐ LEVEL 3 RISK – intolerance / discomfort such as stomach ache after consuming certain foods or drinks
- ☐ LEVEL 4 RISK – lifestyle or religious choices

Additional information/ sheet attached ☐Yes / ☐No

SWIMMING ABILITY (Please tick as appropriate)

☐Unknown ☐Unable to swim ☐Poor swimmer ☐Can swim 25 metres ☐Can swim 50 metres or over

PLEASE TURN OVER

BORNHOFFEN PCYC 3510 NERANG MURWILLUMBAH ROAD NATURAL BRIDGE QLD 4211
Office: (07) 5533 6154 Fax: (07) 5533 6189 Email: bornhoffen@pcyc.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

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	☐Other	

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 SCHOOL OR GROUP