FORM A: TO BE COMPLETED BY ALL STUDENTS

Student Medical Form Confidential

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

SCHOOL: Emerald Secondary College **Home group:** _____

STUDENT'S NAME: _____ **D.O.B:** __/__/_____ **Male □ Female □**

Parent or Guardian – Primary Emergency Contact:

Name: _____ **Relationship:** _____

Phone: (Home): _____ (Work): _____ (Mobile): _____

In the event that I cannot be contacted, please contact:

Name: _____ **Relationship:** _____

Phone: (Home): _____ (Work): _____ (Mobile): _____

Medicare No: _____ **Line #:**___ **Valid to:** _____	**Doctor's Name:** _____ **Telephone:** _____
Private Health Insurance ☐ **Yes** **No** ☐	**Ambulance Subscription** ☐ **Yes** ☐ **No**
Is this the first time your child has been away from home? ☐ **Yes** ☐ **No**	

MEDICAL HISTORY	Tick **Yes or No** to all Questions		**Additional information**: *Details regarding; seriousness, location, date, level of recovery, self-management strategies, required support*
Asthma	[ ] No	[ ] Yes	If YES, complete the FORM 2 **"Asthma Management Form"**
Allergies	[ ] No	[ ] Yes	If YES, complete the FORM 3 **"Allergenic Reaction Management Form"**
Diabetes	[ ] No	[ ] Yes	If YES, attach current management/care plan. A **Fitness to Participate** form signed by treating doctor will also be required. FORM 4
Epilepsy	[ ] No	[ ] Yes	If YES, a **Fitness to Participate** form signed by treating doctor will also be required.
Joint/Muscle/Skeletal issues?	[ ] No	[ ] Yes	
Sight/Hearing impairment	[ ] No	[ ] Yes	
Any serious injuries/illness in the last 12 months?	[ ] No	[ ] Yes	*Date and Nature of injury/Illness*
Is your child currently on any medications?	[ ] No	[ ] Yes	*Name of medication, dosage and requirements (e.g. with food, AM or PM)*
Other: medical condition(s) that may affect participation?	[ ] No	[ ] Yes	*Any physical health issue(s) that require attention or specific support*
Other: learning, psychological, emotional or behavioural issues?	[ ] No	[ ] Yes	*Any concern(s) that require attention or specific support (e.g. management strategies for a successful experience)*
DIETARY Any special requirements?	[ ] No	[ ] Yes	*Details to assist in menu planning (e.g. vegetarian, will eat fish; gluten-free, separate stove)*

SWIMMING ABILITY				
My child can swim 50 metres	[ ] No	[ ] with a struggle	[ ] Comfortably	

FORM B: TO BE COMPLETED IF YOU ANSWERED "YES" TO ASTHMA IN FORM A

Asthma Management Form Confidential

Participant's Name:

Name of doctor treating the participant for this condition:

Doctor's Contact Phone Number:

1) **USUAL ASTHMA ACTION PLAN**

Usual signs of participant's asthma:

☐ Wheeze ☐ Tight Chest ☐ Cough ☐ Difficulty breathing ☐ Difficulty talking ☐ Other_____

Signs participant's asthma is getting worse:

☐ Wheeze ☐ Tight Chest ☐ Cough ☐ Difficulty breathing ☐ Difficulty talking ☐ Other_____

Participant's Asthma Triggers:

☐ Cold/flu ☐ Exercise ☐ Smoke ☐ Pollens ☐ Dust ☐ Other (please describe)_____

ASTHMA MEDICATION REQUIREMENTS (Including relievers, preventers, symptom controllers, combination)

Name of Medication (e.g. Ventolin, Flixotide)	**Method (e.g. puffer and spacer, turbuhaler)**	**When and how much? (e.g. one puff in morning and night, before exercise)**

Does the participant need assistance taking their medication? Yes ☐ No ☐ If yes, how?

_____

Any other information that will assist with the asthma management of the participant while on camp
(e.g. peak expiratory flow, night time asthma or recent attacks)

_____

_____

_____

_____

2) **ASTHMA FIRST AID PLAN** (Please tick preferred Asthma First Aid Plan)

☐ **School Asthma Policy for Asthma First Aid**

Step 1 Sit the person upright
- Be calm and reassuring
- Do not leave them alone.

Step 2 Give medication
- Shake the blue reliever puffer
- Use a spacer if you have one
- Give 4 separate puffs into a spacer
- Take 4 breaths from the spacer after each puff

*You can use a Bricanyl Turbuhaler if you do not have access to a puffer and spacer.
Giving blue reliever medication to someone who doesn't have asthma is unlikely to harm them.

Step 3 Wait 4 minutes
- If there is no improvement, repeat step 2.

Step 4 If there is <u>still</u> no improvement call emergency assistance **(DIAL 000).**
- Tell the operator the person is having an asthma attack
- Keep giving 4 puffs every 4 minutes while you wait for emergency assistance

Call emergency assistance immediately (DIAL 000) if the person's asthma suddenly becomes worse

OR

☐ **Participant's Asthma First Aid Plan** (if different from above)

- In the event of an asthma attack, I agree to the participant receiving the treatment described above.
- Notify in writing if there are any changes to these instructions.

3) **KEY QUESTIONS**

a.	Has asthma interfered with participation in physical exercise within the past 12 months	NO	☐	YES	☐
b.	Has the participant required hospitalization due to asthma in the past 12 months?	NO	☐	YES	☐
c.	Has the participant been on oral cortisone for asthma within the past 12 months (e.g. Prednisone, Cortisone, etc.)?	NO	☐	YES	☐
d.	Has the participant suffered sudden severe asthma attacks requiring hospitalization within the past 12 months?	NO	☐	YES	☐
e.	Does the participant require the use of a nebulizing pump as a part of your regular or emergency asthma treatment?	NO	☐	YES	☐

4) **IMPORTANT NOTE**

If any of the "KEY QUESTIONS" a, b, c, d, or e 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 I for adults) is/am 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 (e.g. 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 the OEG website: (oeg.org.au).

Name: _____ Signature: _____ Date: _____

FORM C: TO BE COMPLETED IF YOU ANSWERED "YES" TO ALLERGIES IN FORM A

Allergenic Reaction Management Form

Confidential

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

A DOUBLE DOSE OF ALL REQUIRED MEDICATION FOR THE PARTICIPANT'S ALLERGIC REACTION MUST BE BROUGHT ON THE COURSE AND NOTED ON THE MEDICAL FORM (e.g. if Epi-Pens or any other type of Auto Injector is required two must be supplied and brought on program).

Student's Name:

Name of doctor treating the student for this condition:

Doctor's Contact Phone Number:

1. What is the student allergic to?
   - Please Specify:

(e.g. Alex is allergic to penicillin and sulpher-based medications)

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

☐ Low - a localised reaction (rash, itching, swelling at the site the trigger/irritant enters)

☐ Moderate - a systemic reaction (rash, itching, swelling away from the site that trigger/irritant enters)

☐ Severe - an anaphylactic reaction (severe breathing problem, total body swell, emergency situation)

Please give details:

3. What medication does the participant take (if any) for their allergic reaction?

4. Medication and treatment to be used during emergency situations:

"KEY QUESTIONS"

5.	Has the participant required hospitalisation due to allergies in the past 12 months?	NO	☐	YES	☐
6.	Has the participant suffered a systemic or an anaphylactic reaction (see question 2 for definition), to their allergy when triggered in the last 10 years?	NO	☐	YES	☐
7.	Does the person take, or has the person been prescribed adrenaline (Epi-pen or similar), when suffering an allergic reaction?	NO	☐	YES	☐

IMPORTANT NOTE:
If any of the "KEY QUESTIONS" 5, 6 or 7 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 I for adults) is/am 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 (e.g. 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 the OEG website: (oeg.org.au).

Name: _____

Signature: _____Date:_____

FORM D: TO BE COMPLETED IF YOU ANSWERED "YES" TO DIETARY REQUIREMENTS IN FORM A

Dietary Requirements Form Confidential

Student's Name:

The YMCA is aware that participants may have an allergy, intolerance or sensitivity to certain food, or a preferred diet for the purpose of cultural, religious and/or other lifestyle considerations. Every effort will be made to accommodate these needs. Please thoroughly complete the questions below to enable us to provide appropriate food and dietary management.
IMPORTANT NOTE: If a dietary requirement is related to an allergy, you are also REQUIRED to complete the Allergic Reaction Management From.

NUT ALLERGIES
Does the participant have a nut allergy? ☐ NO ☐ YES

Do you consent to the participant consuming products with nut warnings? Products carrying warnings such as 'may be present' or 'may contain traces'?
☐ NO ☐ YES

Thoroughly complete the questions below to enable us to provide appropriate food and dietary management.

OTHER ALLERGIES ☐ NO ☐ YES
If any, please specify:

_____

_____

1. Can the participant consume foods marked 'may contain traces of allergen (eg. Milk, egg , etc)? YES/NO
2. Can the participant consume foods with the allergen 'cooked into' the food (eg. Egg in cake)? YES/NO
3. Can the participant share cutlery/pots/pans/cutting boards? YES/NO

DIET INFORMATION
Intolerance **YES/NO**
Please list all foods/ingredients that participant has an intolerance to and provide examples of possible substitutes.
(eg. Dairy Intolerance – soy or rice milk/Fructose Intolerance – No apple, pear, wheat)
Preference **YES/NO**
If diet information relates to a preference, please provide examples of possible substitutes:
(eg. Vegan – soy or rice milk etc. Honey okay?/Vegetarian – cheese and/or milk okay).

_____

_____

Substitutes provided will be chosen according to availability and appropriateness to program requirements and activing type. We may contact you to arrange for additional supply of food from home.

I declare that the information provided on this form is complete and correct.

Name: _____

Signature: _____Date:_____