OUTDOOR RECREATION – STUDENT MEDICAL FORM

Title:		**Gender:**	☐ Male ☐ Female		
Family name:		**Date of birth:**	/ /		
Given name (in full):		**Preferred name:**			
Address:					
Suburb:		**State:**		**Postcode:**	
Phone: (Home)		**(Mobile)**			
Email address:		**Can we contact you by sms?**	Yes ☐ ☐ No		

Medicare Number – Expiry Date – Member number:			
Are you a 'Swimmer': *('swimmer' can swim unassisted for 100 metres)*	Yes ☐ ☐ No	Year date of last tetanus inoculation:	
Do you wear dentures/false teeth:	Yes ☐ ☐ No	Do you wear glasses or contacts:	Yes ☐ ☐ No
Have you ever suffered from a stress related illness:	Yes ☐ ☐ No	If Yes - Please advise details:	
Do you have any past injuries:	Yes ☐ ☐ No	If Yes - Please advise details:	
Specific dietary requirements:	Yes ☐ ☐ No	If Yes - Please advise details:	
Have you undergone surgery in the past 3 years:	Yes ☐ ☐ No	If Yes - Please advise details:	
Do you have any disabilities or illnesses: (e.g. diabetes, epilepsy, dyslexia, deafness, vision impairment, high blood pressure, heart and or lung condition, emotional behaviour disorders)	Yes ☐ ☐ No	If Yes - Please advise details:	
Are there any other medical conditions we should be aware of:	Yes ☐ ☐ No	If Yes - Please advise details:	
Are you currently taking any form of medication:	Yes ☐ ☐ No	If Yes - Please advise details:	Medical condition: Medication name: Dosage & frequency:
Please specify if any of the following medications should NOT be administered to you (tick ☐ No):	Panadol-500mg ☐ No Imodium-2mg ☐ No Ventolin-100mg ☐ No	Nurofen-200mg ☐ No Glucodin-50mg ☐ No Enokot-7.5mg ☐ No	Telfast-180mg ☐ No Gastrolyte-5.2g ☐ No Epi-pen-0.3ml ☐ No
Do you have asthma:	Yes ☐ ☐ No	**If Yes – It is compulsory to complete Appendix 1. and 2.**	
Do you have any known allergies:	Yes ☐ ☐ No	**If Yes – It is compulsory to complete Appendix 2.**	
If yes to any of the above, have you ever been hospitalised for the condition:	Yes ☐ ☐ No	If Yes - Please advise details:	
Does any of your medical conditions impact on your capacity to perform strenuous physical exercise; or would be a risk when working at heights; or could any of your medical conditions pose a potential life threatening risk in the outdoor environment:		Yes ☐ ☐ No	

6 Emergency Contacts: Please ensure you list two emergency contacts and doctors details

1. Name (in full):		**2. Name (in full):**	
Relationship:		**Relationship:**	
Phone (M/W/H):		**Phone (M/W/H):**	
Phone (M/W/H):		**Phone (M/W/H):**	
Address:		**Address:**	
My Doctors Name:		**My Doctors Phone:**	

7 I certify that the information provided in this medical form is true and correct.

Name (in full):		**Signature:**	

Appendix 1.

ASTHMA MANAGEMENT PLAN

To assist us in taking the appropriate precautions, it is important that we have the following information. This level of information is recommended as a minimum by the Asthma Foundation.

Seek the advice of your medical practitioner if necessary when completing this form

Name (in full):		
Known trigger factors:		
Medication name:		
Quantities and daily dosages:		
Additional medication to be taken during an attack: *(please specify name, dosage and reason)*		
Expected best Peak Expiratory flow reading: *(if known)*		
Peak Expiratory flow reading requiring extra medication: *(if known)*		
Peak Expiratory flow reading when advisable to seek medical assistance: *(if known)*		
It is compulsory to also complete Appendix 2.	**I have completed Appendix 2. the Allergic Reaction Management Plan:**	Yes ☐

Other Details:

All medication for the Asthma Sufferer must be brought on the program

Appendix 2.

ALLERGIC REACTION MANAGEMENT PLAN			
Seek the advice of your medical practitioner if necessary when completing this form			
Name (in full):			
Allergic to:			
What are the signs and symptoms of the reaction:			
Have you at any time in the past suffered from:	**A localised reaction**: *(any rash, itching, swelling at the site the poison has entered)*		Yes ☐ ☐ No
	A systemic reaction: *(any rash, itching swelling away from the site where the poison has entered)*		Yes ☐ ☐ No
	An anaphylactic reaction: *(severe breathing problems, swelling of the body, emergency situation, loss of consciousness)*		Yes ☐ ☐ No
What medication do you take (if any) for prevention against an allergic reaction:	**Medication name:**		
	Dosage & frequency:		
What treatment is followed if an allergic reaction occurs:			

Six vital questions :	
1. Do you suffer a systemic reaction to your allergy/asthma	Yes ☐ ☐ No
2. Do you have an anaphylactic reaction to your allergy	Yes ☐ ☐ No
3. Is there a family history of anaphylaxis	Yes ☐ ☐ No
4. Have you ever been hospitalised due to an allergic reaction/asthma attack	Yes ☐ ☐ No
5. Is adrenaline (eg adrenaline injection, epi-pen) administered when you suffer from an allergic reaction/asthma attack	Yes ☐ ☐ No
6. Has oral steroid use been part of the treatment for you allergy/asthma	Yes ☐ ☐ No

If **YES** has been answered to any of these 6 vital questions your Medical Practitioner must be consulted about your participation in the program;

Participation will depend on a medical clearance by your Medical Practitioner.

Your Medical Practitioner is to be advised of the following information:

- On wilderness programs the participant may be more than 4 hours away from medical/hospital treatment
- TAFE staffs have current first aid qualifications and carry Remote Area or Wilderness First Aid kits

Other Details:

All medication for the Sufferer's allergic reaction must be brought on the program