

CAMP MEDICAL FORM

ADYO

Adelaide Youth Orchestras

My daughter/son _____

of _____
(orchestra)

has my permission to attend _____

from / / to / /

91 Hindley Street
Adelaide SA 5000

GPO Box 2121
Adelaide SA 5001

T. 08 8233 6256
F. 08 8233 6272
E. adyo@adyo.com.au
W. www.adyo.com.au

ABN 53 037 804 043

Please print in the following confidential details concerning your child:

Home Address		
Contact Ph Numbers	Mother's Name	Father's Name
	H	H
	W	W
	Mob	Mob
Alternative Contact If Above Unavailable.	Name	Relationship
	H	
	W	
	Mob	

Food allergies / dietary needs	
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Date of Birth / /	Age	Medicare No. (inc personal digit)
Private Medical Insurance Y/N. If YES, Fund and Policy No.		Ambulance Cover: Y / N. If YES, Policy No.

Doctor:	Phone:
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Dentist:	Phone:
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Are there any pastoral, cultural or religious issues that may affect participation or medical treatment? If YES please write, or attach details and necessary procedures to be followed:	YES / NO

Has your child suffered from any illness or injury within the last 3 months? If YES, please detail.	YES / NO

Does your child suffer from environmental or medical drug-related allergies ? If YES please write, or attach details describing triggers, reactions and normal treatment:		YES / NO
Type of allergy:	Triggers and reactions:	Treatment:

Does your child have Asthma ? IF YES please complete the following		YES / NO
Triggers: Usual Symptoms: Prevention medication: Reliever medication:		
Please select ONE preferred treatment plan		
AdYO's Asthma Policy	YES/NO	Alternative Plan
Step 1: Sit person upright and stay calm Step 2: Give 4 separate puffs of a blue reliever (Airomir, Asmol, Bricanyl or Ventolin). The medication is best taken one puff at a time via a spacer device. Take 4 breaths from the spacer after each puff of the medication. Step 3: Wait 4 minutes. Step 4: If little or no improvement, repeat steps 2 and 3. If still no improvement, call an ambulance (000), state that "a student is having an asthma attack". Continuously repeat steps 2 and 3 while waiting.		YES/NO Please write below, or attach details of dosages, method and frequency. You will need to supply all medication and equipment. Note that access to power may be infrequent.

Does your child suffer any other condition that may affect full participation, or safe management (eg diabetes, epilepsy, heart condition...)? If yes, please supply details, medication, name and contact number of doctor treating condition.	YES/NO

Can your student swim 50m , unassisted, in a swimming pool?		
Not at all	With difficulty	Easily

Has your child had a tetanus booster ? If yes, please state date of last booster: / /	YES / NO
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Prescription and Restricted Medicines

These should be identified below, and would be normally given to the accompanying teacher. Please supply medicine in original container, with label clearly displaying student's name and dosage details.

Medicine	Dosage details

Non-prescription Medications.

The following may be held by staff for relief of minor ailments. Not all sites may have every medication.

Nurofen (Aspirin based)	Telfast (anti-histamine)	Cold/Flu medication
Paracetamol	Claratyne (anti-histamine)	Strepsils
Ventolin inhaler	Stingose	Eyedrops

Please tick ONE of the three options below

- All** medicines listed above may be administered when necessary
 No medicines listed above may be administered
 All medicines listed above may be administered when necessary, **EXCEPT** for the following:

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Consent

I authorise the staff in charge of the camp/excursion/tour to consent to my child receiving such medical treatment as deemed necessary in an emergency, including blood transfusion and administration of an anaesthetic if it is impracticable to communicate with me. I agree to pay all medical/dental expenses and transport costs, incurred on behalf of my child, as a result of any condition or injury sustained by my child.

I also agree to pay the transport costs of returning my child home because of serious misbehaviour.

Signature of parent or legal guardian of student		Date: / /
Printed Name		