Burwood Adventist Community Church

Medical Information & Consent for Emergency Treatment & Transportation

USE

This document should be used in conjunction with the template local church 'Child-Safe Policy' (v 2013 or subsequent editions) and applicable Conference & AUC / NZPUC policy.

PURPOSE

The purpose of this form is to enable the local Church and its Pathfinder Club, and/or other similar Church-sponsored activities and programs for children and young people, to collect and access medial and emergency information to assist it fulfil its duty of care particularly during off-site, overnight, or outdoor activities where a child or young person's regular parent or guardian may not be present or in attendance.

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Medical Information and Consent for Emergency Treatment & Transportation

BURWOOD ADVENTIST COMMUNITY CHURCH

Details of Child or Young Person:

Name: _____ DOB ____ / ____ / ____ Gender: M / F

Emergency Contact (Parent / Guardian):

Name: _____ Relationship to Child: _____

Phone (Mobile): _____ Phone (Alternative) _____

Address: _____ P/Code _____

Medicare & Private Health Cover:

Medicare number: _____ Is the child covered by private health insurance? Y / N

If Yes, name of insurer/fund: _____ Policy number: _____

Does the policy cover: Ambulance? Y / N Basic Hospital Bed? Y / N

Medical Contact:

Name of Usual Doctor / Clinic: _____ Phone _____

Address:

_____

Known allergies or reactions to medications including pain killers:

_____

Details of any ongoing prescribed substance or recommended medication:

Condition (if this is a potential source of embarrassment, please advise on a separate piece of paper and speak with a leader / supervisor / first aid / designated medical officer or camp nurse, about the condition)

Name of substance 1: _____ Dose: _____ Frequency: _____

Name of substance 2: _____ Dose: _____ Frequency: _____

Name of prescribing registered medical practitioner:

_____

Can the child or young person self-administer? Describe:

_____

Pre-existing Conditions:

Heart Trouble	Yes / No	Describe
Respiratory Problems	Yes / No	Describe
Asthma	Yes / No	Management plan?
Blood pressure	Yes / No	Describe
Epilepsy	Yes / No	Describe triggers / response plan
Allergies	Yes / No	Describe in detail, e.g. bees; plants; food etc. & impact Would hospitalization usually be required? Y / N
Phobias	Yes / No	Describe
Recent Operations	Yes / No	Any likely effects, or signs and symptoms to monitor?
Dietary Requirements & Preference Known intolerance to gluten, diary, any preservatives, colours, flavourings, or synthetic anti-oxidants and the like?	Yes / No Yes / No	Describe Describe
Swimmer	Yes / No	Competent Distance
Other relevant information?	Yes / No	Describe

Parent / Guardian Consent

I, (full name) _____, being the Parent / Guardian of the above named child or young person declare that the above is correct to the best of my knowledge at the time of completing this form. I permit the above named child or young person to be transported to a hospital or other professional medical care facility in an emergency, including by ambulance, in the event that either I or the emergency contact person named above are unavailable or cannot be contacted for any reason.

Signed: _____ Date: ___ / ___ / _____