Confidential

Adult Medical Form

The purpose of this form is to help us adequately prepare for your program. This information is confidential and participants will not normally be excluded for medical reasons. **(PLEASE COMPLETE IN FULL IN BLACK OR BLUE INK)**

SCHOOL:…… **Male** ☐ **Female** ☐

NAME:…… **Contact Phone**:…… **D.O.B**:……/……/……

Emergency Contact:

Name:…… **Relationship**:……

Phone: (Home)…… **(Work)**:…… **(Mobile)**:……

Medicare No: ☐☐☐☐☐☐☐☐☐☐ **Valid to**:……

Doctor's Name:…… **Telephone**:……

MEDICAL HISTORY	Please tick either **Yes** or **No** to all questions		**Provide detailed information:** *How serious is it? What is it? When? Has it fully recovered? Any known triggers? Is it self managed? Anticipated special management needed?*
Asthma	☐ **N**	☐ **Y**	If YES, complete the **'Asthma Management Form'**
Allergies	☐ **N**	☐ **Y**	If YES, complete the **'Allergenic Reaction Management Form'**
Diabetes	☐ **N**	☐ **Y**	If YES, attach current management / care plan. A **'Fitness to Participate'** form signed by treating doctor will also be required.
Epilepsy	☐ **N**	☐ **Y**	
Joint/Muscle/Bone problems	☐ **N**	☐ **Y**	
Sight/Hearing Impairment	☐ **N**	☐ **Y**	
Any serious injuries/illness in the last 12 months?	☐ **N**	☐ **Y**	
Are you currently on any medications?	☐ **N**	☐ **Y**	*Please name the medication and dosage*
Other medical condition that may affect participation?	☐ **N**	☐ **Y**	*Any health, psychological or learning issues that require attention or special care?*

DIETARY Any special requirements?	☐ **N**	☐ **Y**	If vegetarian, do you eat fish or white meat?

SWIMMING ABILITY I can swim 50 metres	☐ **No**	☐ **with a struggle**	☐ **comfortably**	☐ **strongly**

Please note: *OEG may require, after reviewing this information, that you visit a doctor to gain approval to participate. This will be determined after this form is received by OEG and in consultation with you.*

Office Use Only:

I declare that the information which I have provided on this form is complete and correct and that I will notify the school if any changes occur. I authorise the school or any employee of the Outdoor Education Group to give consent where it is impractical to communicate with me, and agree to receiving such medical or surgical treatment as may be deemed necessary. I give permission for OEG to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment. I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per the Privacy Policy documented on our website: (oeg.org.au).

Name:…… **Signature**:…… **Date**:……

Photograph Consent: I consent to being photographed and/or having visual images of me taken during activities, for use in OEG publications, on the OEG website, or for publicity purposes without acknowledgment and without being entitled to any remuneration or compensation. ***(Please strike out this sentence if you do not agree)***

THE ASTHMA FOUNDATION

The Outdoor Education Group
Eildon Office: Private Bag 1109, Eildon, Vic 3713 Ph: (03) 5774 2617 F: (03) 5774 2467
Moss Vale Office: P.O. Box 682, Moss Vale, NSW 2577 Ph: (02) 4869 6700 F: (02) 4869 6767

Asthma Management Form

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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 & spacer, turbuhaler)**	**When and how much? (e.g. 1 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 steps 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.

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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 hospitalisation within the past 12 months?	NO	☐	YES	☐
e.	Does the participant require the use of a nebulising pump as a part of your regular or emergency asthma treatment?	NO	☐	YES	☐

4) IMPORTANT NOTES

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 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 our website: (oeg.org.au).

Name: _____ Signature: _____ Date: _____

The Outdoor Education Group

Allergenic Reaction Management Form **Confidential**

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

A DOUBLE DOSE OF ALL MEDICATION REQUIRED 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 2 x must be supplied and brought to camp).

Student Name:

Name of doctor treating the student for this condition:
Doctor's Contact Phone Number:

1. What is the student allergic to?

Bites: ☐ Foods: ☐ Medications: ☐ Stings: ☐ Other: ☐

Please Specify:

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

☐ Low - a localised reaction (rash, itching, swelling at the site the poison/irritant enters)
☐ Moderate - a systemic reaction (rash, itching, swelling away from the site that poison/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 NOTES:
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 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 our website: (oeg.org.au).

Name: _____ Signature: _____Date: _____

The Outdoor Education Group

Fitness to Participate Form

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School Name: _____ Year Level: _____

Name of Participant: _____ D.O.B. _____

Specific Medical Condition: (e.g. Asthma, Allergies) _____

Notes to treating Doctor

This patient is scheduled to participate in an Outdoor Education program and has self-identified a pre-existing medical condition on their medical form.

Outdoor Education programs with OEG are centred in a 'semi-wilderness' setting, meaning that professional medical care may be from 1 to 6 hours away. All programs include regular physical exercise and activities may include bushwalking (with packs), camping, cycling, rock climbing or canoeing. We operate in all weather conditions.

(Should you require any further information on the program, please contact us at (02) 4878 5393 and quote the name of the client organisation and year level listed at the top of this page)

OEG staff hold a Wilderness First Aid qualification (minimum of 7 days training). This training is based on assessing and treating a patient in a remote or wilderness setting. For more information see http://www.wms.org/

Doctor to complete:

Based on this information above and the patient's condition, we ask that you decide on this person's suitability to participate in the upcoming program. If approved, please include specific treatment protocols to follow in the event of an emergency.

Do you approve this participant attending an Outdoor Education program, based on their current medical condition, coupled with the demands of the program?

□ Yes □ No

What treatment protocol are you willing to authorize for this patient in the case of a medical emergency, in a remote location (i.e. one or more hours away from medical care)?

_____
_____
_____
_____

What should the OEG staff managing this participant in the field be informed/aware of, in regards to the particular situation for this patient? What are the recommended parameters for participation in the activities?

_____
_____
_____
_____
_____

Name of Doctor: _____ **Phone:** _____

Signature of Doctor: _____ **Date:**_____

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 our website: (oeg.org.au)