

# Adelaide Metro Christian Life Week 2012 Under 18 Medical & Personal Information



## Protecting your family, and your family's privacy

ChildSafe is the Lutheran Church of Australia's (LCA) national Risk Management system which is administered through the Districts to comply with State legislations and our God-given mandate to care and provide safe programs for the young in our midst. LCA SA/NT Blueprint Ministries' compliance with the safety procedures of ChildSafe gives parents like you more confidence to involve your children in our program.

Protecting your family's privacy is important to us. The information we seek allows us to manage risk, provide reasonable care and administer your child's involvement in our program. We are careful to keep your family's information confidential, and provide it only to those agents acting on behalf of LCA SA/NT Blueprint Ministries who need it to enable them to perform their agreed activities (e.g. First Aid officers, Leaders, promotions etc.). We will not use your information for other purposes unless given written consent from you. You are welcome to contact the District Office in relation to issues regarding your personal information and for a copy of our Privacy Policy.

We only ask for information that is necessary for the purposes outlined in this statement. In some circumstances, if you don't provide us with all requested information, your child could miss the opportunity to be involved in our camp.

**We apologise for doubling up information that you have already filled out on the registration form, but this form is crucial.**

## Participant Details

Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M F  
Residential Address: \_\_\_\_\_  
Postal Address (if different): \_\_\_\_\_

## Caregiver(s) Details

Name(s): \_\_\_\_\_  
Relationship to Participant: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Mobile: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

## Alternative Emergency Contacts

In the event that parents/guardians cannot be contacted in an emergency, please list phone numbers of two others who may be contacted during the course of the week.

| Name  | Relationship | Number |
|-------|--------------|--------|
| _____ | _____        | _____  |
| _____ | _____        | _____  |

## Dietary Requirements

Does your child have any special dietary requirements? If so, please list the details and whether we need to purchase specific products, or if you will be providing any, eg soy milk:

## Medical Information

Please give details of your child's medical insurance if applicable

Insurance Provider: \_\_\_\_\_ Membership Number: \_\_\_\_\_  
Medicare Number: \_\_\_\_\_ Number of person on card: \_\_\_\_\_ Expiry Date: \_\_\_\_\_  
Ambulance Cover number: \_\_\_\_\_ Health Care Card number (if applicable): \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Number: \_\_\_\_\_  
Family Dentist: \_\_\_\_\_ Number: \_\_\_\_\_

Are there any conditions which require special attention that we should know about, eg hearing or sight impairment, ADD or ADHD, behaviour issues, formal counselling situations, or any other? *Please list below*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMPORTANT: Please note that it is our policy that team members (CLW Leaders) do not provide non-prescription medications, such as paracetamol (e.g. Panadol). Senior First aid officers can only administer participant supplied medications upon your consent.**

Will your child need to take tablets or any other medication during the course of the program ☐ Yes ☐ No  
 If yes, please give details of the medication, when required, dosage, and when to be taken, eg 2 tablets with breakfast every day (Any medication must be presented to the designated leader before boarding the bus or upon registration at the campsite)

Has your child been taken off any medication recently? If yes, please give details ☐ Yes ☐ No

Has your child previously broken/fractured any bones? If yes, please give details ☐ Yes ☐ No

What was the year of your child's last tetanus injection? \_\_\_\_\_

Is your child subject to sleep walking? ☐ Yes ☐ No

**Specific Medical Conditions** Please indicate if your child has had any of the conditions below. Provide additional details if necessary.

| Condition       | Past                     | Present                  | severity, treatment, etc | Condition        | Past                     | Present                  | severity, treatment, etc |
|-----------------|--------------------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|--------------------------|
| Asthma          | <input type="checkbox"/> | <input type="checkbox"/> |                          | Hyperactivity    | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Appendicitis    | <input type="checkbox"/> | <input type="checkbox"/> |                          | Hypo activity    | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Bronchitis      | <input type="checkbox"/> | <input type="checkbox"/> |                          | Heart Problems   | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Chicken Pox     | <input type="checkbox"/> | <input type="checkbox"/> |                          | Measles          | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Diabetes        | <input type="checkbox"/> | <input type="checkbox"/> |                          | Mumps            | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Ear Infections  | <input type="checkbox"/> | <input type="checkbox"/> |                          | Pneumonia        | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Epilepsy        | <input type="checkbox"/> | <input type="checkbox"/> |                          | Tonsillitis      | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Fits/Convulsion | <input type="checkbox"/> | <input type="checkbox"/> |                          | Allergy - foods  | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Faint/Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |                          | Allergy - animal | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Glandular Fever | <input type="checkbox"/> | <input type="checkbox"/> |                          | Allergy - other  | <input type="checkbox"/> | <input type="checkbox"/> |                          |

### Agreement

I am willing that my child should participate in the Metro Christian Life Week camp. I understand that the nature of the activities at CLW may include, but are not limited to; bus travel, walking, games, dormitory accommodation, communal eating, worship, prayer, small group discussions, sports and the risks that are associated with these activities.

Are there any specific activities that you do not wish your child to participate in? ☐ Yes ☐ No

If yes please specify \_\_\_\_\_

**Your agreement with LCA SA/NT Blueprint Ministries Inc.** (Please tick when read and consented to)

☐ I am aware in signing this document for my child's participation in this program that certain elements of the program could be physically and emotionally demanding. Furthermore, I understand that certain inherent risks and dangers exist in the activities in which my child will be participating.

☐ I acknowledge that while LCA SA/NT Blueprint Ministries Inc. and its leaders, volunteers and staff will make every reasonable effort to minimise exposure to known risks, all hazards and dangers associated with these activities cannot be foreseen or may be beyond the control of LCA SA/NT Blueprint Ministries Inc., its leaders, volunteers and staff.

☐ I confirm that the information contained in this registration is true and correct.

☐ I agree to inform the camp directors Andrew Traeger or Peter Eckert, in writing of any changes to these details during 2012 (inclusive).

**In the event of an emergency where I/we and my nominated contact people are unavailable:**

☐ I authorise the leaders to obtain medical advice and/or assistance which they deem necessary.

☐ I further authorise qualified medical practitioners to administer anaesthetic if required.

☐ I accept all operation, blood transfusion and/or anaesthetic risks involved in the event that such procedures are deemed necessary.

☐ I accept responsibility for payment and agree to pay medical, transport and any other related expenses.

Name of caregiver: \_\_\_\_\_ Signature of Caregiver: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/2012

### Participant Agreement

As a camper on Metro Christian Life Week; I agree to participate in all events to the best of my abilities and to follow the direction of camp leaders and directors at all times. I agree to do everything I can to build the camp community, and to help make the camp a success for everyone, both campers and leaders. I agree to comply with camp rules, and understand the consequences of breaking them may include my family being notified and me being sent home from camp. I also agree that CLW is a drug and alcohol free camp.

Name of Camper: \_\_\_\_\_ Signature of Camper: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/2012

**PLEASE POST MEDICAL FORMS BACK TO "Metro CLW, 15 Strutt Court, Trott Park, 5158"**