

Consent and Medical Form

Please complete the required information and check all appropriate boxes below to indicate your agreement/consent:

- During the COVID-19 pandemic we are taking additional steps to make sure everyone can stay healthy and safe. It is very important that you inform us in advance if anyone in your household is unwell, or self-isolating because they are at risk of becoming unwell with COVID-19. If you are unwell, please stay at home and don't attend this event.
- We recommend all participants to have downloaded and run the COVIDsafe App; helping speed up the traceability of people exposed to coronavirus. We will be conducting temperature checks as a preventative measure in managing COVID-19 in our outside workplace.
- We recommend that, where possible, all participants to bring and use their own Personal Protective Equipment (PPE), including helmets, gloves, etc for the duration of the activities
- We will be implementation additional safety measures including physical distancing measures, hand washing, and personal hygiene practices to keep our members safe during this time.
- I am aware of the risks involved with the activity and agree to delegate my authority to the staff and instructors involved. I acknowledge that while the organisation, its staff, associated instructors and volunteers will make every reasonable effort to minimize exposure to known risks; all hazards and dangers associated with these activities cannot be foreseen or may be beyond the control of the school, its staff, volunteers and associated instructors. I agree to waive any claims of liability that may arise against any school personnel relative to the activity.
- I have provided the OEAQ with all relevant details relating to my medical or physical needs whilst undertaking these activities day and will keep you updated if this information changes
- In the event of an accident or illness, if I am unable to be contacted, I authorise OEAQ members to obtain or administer any medical assistance or treatment I may reasonably require, including contacting my doctor. I authorise qualified medical practitioners to administer an anaesthetic if such an eventuality arises, and agree to pay all medical, ambulance and pharmaceutical expenses incurred on behalf of myself.

Name: _____ (Please Print)

Signature: _____ Date: ____/____/____

Medical Update Information

The Association collected medical information about you prior to an activity . This information is stored in the OEAQ database. Please give full details of any new or changing conditions (medical, physical or management) which may affect your child's full participation in the activity described in the form.

Please provide the following information:

Name of your medical practitioner: _____ Telephone No.: _____

Medicare No: _____ Number on Card: _____ Exp. Date: _____

Private Health Insurance Company (if provided): _____ Membership No.: _____

Privacy Notice

The OEAQ is collecting the personal information requested in this form in order to:

- obtain lawful consent for you to participate in the activity;
- help coordinate the activity;
- respond to any injury or medical condition that may arise during, or as a result of the activity; and
- update personal records where necessary.

The information will only be accessed by authorised OEAQ Volunteer staff and will be dealt with in accordance with the confidentiality requirements of sport and recreational business entities. The information will not be disclosed to any other person or agency unless it is for a purpose stated above, the disclosure is authorised or required by law, or you have given OEAQ permission for the information to be disclosed.

MEDICAL UPDATE INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Home Number: _____ Work Number: _____

Mobile No. 1: _____ Mobile No. 2: _____

Emergency Contact: _____ Relationship: _____

Contact's Ph.: _____ Contact's Mobile: _____

If the answer to any of these is 'yes', you must provide detailed information, including: the nature and severity of the condition, possible triggers, ability of the student to recognize and manage their own condition and any emergency action plan or protocols that have been developed for the student or their condition.

1. Immunization Schedule

Tetanus	Yes / No	Date of last injection _____
Meningococcal	Yes / No	Date of last injection: _____
Influenza	Yes / No	Date of last injection: _____
Childhood Illnesses	Yes / No	Date of last injection: _____

2. Allergies Yes / No _____

3. Travel Sickness Yes / No _____

4. Blood Pressure Problems Yes / No _____

5. Diabetes Yes / No _____

6. Operations (recent) Yes / No _____

7. Recent or recurring illness Yes / No _____

8. Medication required Yes / No _____

Please be aware that any medication (except asthma puffers) that parents wish staff to administer, must include:

- a) A fully completed and signed student medication request form.
- b) The original pharmacy label detailing the name of the person authorised to take the medication, dosage, time to be taken and Medical Practitioner's name, as staff will follow the directions on the original label attached to the medication container.

9. Drug reactions (eg penicillin) Yes / No _____

10. Respiratory problems Yes / No _____

11. Heart problems Yes / No _____

12. Epilepsy Yes / No _____

13. Swimming ability (please circle one) Cannot Swim Weak Swimmer (< 50m) Fair Swimmer (50-100m)
Competent Swimmer (100-200m) Strong Swimmer (200m+)

14. Special dietary requirements _____

Other (including migraine, fainting, dizzy spells, phobias, ADHD):

Signature: _____ **Date:** _____