



CLEM JONES CENTRE – WATER SAFETY WEEK

MEDICAL AND CONSENT FORM

FULL NAME.....D.O.B:

HOME ADDRESS.....

.....

HOME TELEPHONE.....

MOBILE.....

EMERGENCY CONTACT AND

TELEPHONE.....

MEDICAL INFORMATION: (tick for yes)

Has team member current tetanus cover

Does team member suffer from:

Asthma

Respiratory problems

Heart Problems

Diabetes

Epilepsy

Any other medical problems

If so please note

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Any current sports injuries

Allergies to

Food

Drugs

Insect or bee stings

(Does member carry antihistamine)

PLEASE COMPLETE OVER

Any other relevant information for Staff Members

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Details of medications currently being taken (please include puffers)

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Medicare Number

Private Health Fund & Number

Ambulance Cover: Yes / No

PARENT / GUARDIAN CONSENT FORM

1. I authorise the CLEM JONES CENTRE STAFF to obtain medical attention for my child at his / her discretion in the event of illness or injury.
2. I agree to pay any costs incurred for medical treatment, pharmaceutical products required or / and ambulance fees deemed necessary by the team managers.
3. I am aware of the program of activities in which my child will take part.
4. I consent to photos/video footage of my child/ren participating in the Safety Week Program and that these images may be posted in Newspapers and used on the Centre's website and for future advertising.

Parent / Guardian's Signature

Please Print Name

Parent Contact Number

Date