VOLUNTEERING MATTERS

PARTICIPANT AGREEMENT

Activity name: ....……………………

I (Parent/guardian name).. ………

of (Address) .... ………

Telephone (H) .... (Mob) ....(W)... ……..

Agree to my son/ daughter/ ward (child name).. ……..

participating in (activity name) .... ……..

I (and or my son/daughter/ward) agree and understand that:

- ❒ The activity will be supervised.
- ❒ I/they will attend the activity entirely at my/their own risk and will exercise due care to ensure my/their personal safety and that of others occurs.
- ❒ I declare that the person whose name appear above has no known medical or physical condition that may be made worse by participation in the activity or precludes me/them from participating in the activity (If so, please detail on the back of this form)
- ❒ I will undertake that the person whose name appears above and or myself will conduct myself/themselves in a safe and responsible manner for the duration of the activity.
- ❒ I undertake that the person whose name appears above will follow any reasonable direction or advice affecting my safety given to me/them by event organisers.
- ❒ I accept all risks associated with the activity for myself and my heirs, executors and assignees and release the organisation and its servants and agents from all claims, actions, suits, and demands from loss or injury to me or my dependents arising from my participation in this activity.

- ❒ I hereby consent and agree to the organisation using photographs, video or film likeness of the persons whose name arrears above for promotional or educational/training purposes.

I have read this indemnity agreement and I fully understand its contents.

Signed …………………………… Name: ………………………… Date:..................................
(**NOTE**: To be signed by a parent or guardian when the participant in under 18 years of age.)

If you have any questions regarding the activity contact: ....

....
Note:
....
....
....

VOLUNTEERING MATTERS

MEDICAL CONSENT FORM

Organisation name: ....

Activity: ....date/s:..

The purpose of this form is to allow us to adequately prepare for your safe participation in this activity. This information will be kept strictly confidential.

Participant Details

Name.. ……………………………D.O.B. ....

Mobile .... Work/Alt Ph: …………………… AH Ph: …………………………

Address... Postcode:........

Gender ❒ Female ❒ Male Medicare Number ....

Your Doctor ....Phone ....……

Specific dietary requirements you have. ....…….

Emergency Contact/s

Name ....Relationship...

Phone (please give the best number for us to use) ……………………………………………………….

Alternative phone..…..

Address ....…

2nd Emergency Contact/s

Name ....Relationship..

Phone (please give the best number for us to use)..

Alternative phone..

Address ....

Disabilities / injuries

Do you have any disabilities or illnesses? **❒No** **❒Yes**

Please give details. ....….

....….

..

Are there any other medical conditions we should be aware of?

....

....

VOLUNTEERING MATTERS

Allergies

Do you have any known allergies? ❒**No** ❒**Yes,**
If yes you must also complete the Allergic Reaction management plan (following pages)

What is your/their allergy?

Asthma Do you suffer from asthma? ❒**No** ❒**Yes** Please complete the asthma management plan on next page.

Medications Are you currently taking any form of prescribed medication? ❒**No** ❒**Yes** If yes, detail name, dosage and frequency
……
……
……
This medication MUST be carried by the participant while on program.

Parent / legal guardian declaration

I agree to my child's/ward's attendance at the above mentioned program.

In the case of an emergency, I authorise the program organisers/staff, where it is impracticable to communicate with me, to arrange for my child/ward to receive such medical or surgical treatment as may be deemed necessary. I also undertake to pay or reimburse costs which may be incurred for medical attention, ambulance transport and drugs and other costs while my child/ward is enrolled/attending the event/activity/program.

I understand that although the organisation tries to minimise any risk of personal injury within all practical boundaries, accidents do happen and all physical activities carry the risk of personal injury. I acknowledge that there is an inherent risk of personal injury in physical activities that will be undertaken as part of this event/activity/program

Parent / Legal Guardian……………………………………………………………………… **Date** ....../......../........

Statistics (optional)

To help us keep statistics on our programs, please answer the following questions.

1. Are you: ❒ Aboriginal ❒ Torres Strait Islander ❒ Not Aboriginal or TSI

2. Are your parents from a non English speaking background? ❒ Yes ❒ No

VOLUNTEERING MATTERS

Asthma Management Plan

Only complete this page if the participant suffers from asthma.

It is important that we have the following information, to help us take the best precautions for your/wards safety. This level of information is recommended as a minimum by the Asthma Foundation. Please get advice from your medical practitioner if necessary when completing this section.
This information will be kept strictly confidential.

Name of participant: ....

Regular medication:..

Quantities and daily dosages: ....

Additional medication to be taken during an attack: ....

The medications listed above must be given to the organiser/staff/ event supervisor prior to commencement of the event/activity/program.

Expected best Peak Expiratory flow reading: ....

Peak Expiratory flow reading requiring extra medication: ....

Peak Expiratory flow reading when advisable to seek medical assistance: ....

Known trigger factors (please tick any appropriate item)

- ❒ Dust of any sort, in sufficient quantities
- ❒ Contact with animals
- ❒ Atmospheric pollution
- ❒ Other ....
- ❒ Sudden change in temperature
- ❒ Grass and weed pollens, mould
- ❒ Vigorous exercise

Details: ....

....

....

....

....

....

Parent/Legal Guardian.. **Date** ....../......../........

VOLUNTEERING MATTERS

Allergic Reaction Management Form

Only complete this page if the participant suffers from allergic reactions.

It is important that we have the following information, to help us take the best precautions for your/wards safety.
This information will be kept strictly confidential.

Seek the advice of your medical practitioner if necessary when completing this form.

Name: ....

Allergic to ....
What are the signs and symptoms of the reaction (what should we be looking out for)?

....

....

Have you at any time in the past suffered from?

- ❒ **A localised reaction** (any rash, itching, swelling at the site the poison has entered)
- ❒ **A systemic reaction** (any rash, itching swelling away from the site where the poison has entered)
- ❒ **An anaphylactic reaction** (severe breathing problems, swelling of the body, emergency situation)

What medication do you take (if any) for prevention against an allergic reaction?..................................
....
....

All medication for the sufferer's allergic reaction must be brought on the activity/event/program and given to the supervising officer/ event/program organiser worker in charge.

What treatment is followed if an allergic reaction occurs? ....
....
....

Five vital questions – (please answer by circling)

1. Do you suffer a systemic reaction to your allergy? **❒No** **❒Yes**
2. Do you have an anaphylactic reaction to your allergy? **❒No** **❒Yes**
3. Is there a family history of anaphylaxis? **❒No** **❒Yes**
4. Have you ever been hospitalised due to an allergic reaction? **❒No** **❒Yes**
5. Is adrenaline (eg adrenaline injection, epi-pen) administered when you suffer from an allergic reaction? **❒No** **❒Yes**

If you have answered 'yes' to **any** one of these 5 vital questions, you must:
*** Consult your doctor about participation in the program.**
*** Have the full agreement of the Coordinator and your Medical Practitioner.**

The medical practitioner is to be advised about the nature of the program, and the above is true and correct.

Parent/Legal Guardian.. **Date** ....../......../........