

MITTAGUNDI MEDICAL & PERMISSION FORM - Parent or Guardian to complete

The purpose of this form is to help us adequately prepare for your child's program. This information is confidential and students will not normally be excluded for medical reasons.

PARTICIPANT DETAILS	
Name:	DOB:
Address:	[] Male [] Female
Email:	Mobile:
School Attended:	Medicare Number:
Course Dates:	

PARENT/ GUARDIAN CONTACT	
Name:	Relationship:
Address:	Phone:
Email:	Mobile:

SECOND EMERGENCY CONTACT	
Name:	Relationship:
Address:	Phone:
Email:	Mobile:

MEDICAL HISTORY			
Does your child suffer from any form of ASTHMA?	[] YES (complete Asthma Form)	[] NO	
Does your child suffer from any ALLERGIES?	[] YES (complete Allergy Form)	[] NO	
Does your child have any of the following conditions?:			
Diabetes	[] YES [] NO	Heart Condition of any kind	[] YES [] NO
Epilepsy	[] YES [] NO	Hip, knee or ankle injury	[] YES [] NO
Bleeding Disorder	[] YES [] NO	Currently taking any medication	[] YES [] NO
Psychological Condition	[] YES [] NO	Migraines or Headaches	[] YES [] NO
Contact Lenses	[] YES [] NO	Sight or Hearing Disorder	[] YES [] NO
Special Dietary Requirements	[] YES [] NO	Sleep walking or vertigo	[] YES [] NO
Provide complete details for questions to which the answer is YES (Use a separate sheet if necessary): Include complete list of medications: _____ _____ _____			
Has your child suffered any recent or relevant illnesses or injuries not covered in an earlier question, or undergone surgery recently? Yes / No If yes, please supply details _____			
My child can swim 50 meters: [] Not at all [] With a struggle [] Comfortably [] Strongly			
Date of child's last Tetanus injection:			

PARENT/ GUARDIAN DECLARATION

I am aware that the Mittagundi and Wollangarra Alpine Walk, in addition to the usual risks inherent in outdoor activities, has certain additional risks and dangers which may include: physical exertion for which my son/daughter may not be prepared, remoteness from normal medical services and weather extremes.

I am aware that the Mittagundi and Wollangarra Alpine Walk structure involves my son/daughter in the activities of 10 day bushwalk through the Victorian High Country. It will also involve campfire cooking and using a flying fox.

I realise that Mittagundi and Wollangarra cannot be expected to cover medical costs that may arise during the course, associated ambulance costs, lost or damaged personal items, and I agree to be liable for such costs or losses and to arrange for any relevant insurance covers I consider necessary before the course.

I give my son/daughter permission to attend this Mittagundi Course.

I declare that the information which I have provided on this form is complete and correct and that I will notify Mittagundi if any changes occur. I authorise the teacher or any Mittagundi team member who is with my child, to give consent where it is impractical to communicate with me, and agree to my child receiving such medical or surgical treatment as may be deemed necessary. I give permission for Mittagundi to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment of my child. I give permission for Mittagundi to retain this form in their archival program information, noting that I can access it by appointment.

I acknowledge that I have read all the information provided, and that I have completed and attached the medical forms. I also understand that whilst at Mittagundi if my child behaves in any manner that may risk their own or others' safety, or is deemed by the staff to be unacceptable, then their participation on the program may be discontinued.

Photograph Consent: I consent to my child being photographed and/or visual images of my child being taken during activities, for use in Mittagundi publications, on the Mittagundi 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)

Signed: _____ (Parent/ Guardian) Date: _____

PARTICIPANT DECLARATION

I agree to abide by the Mittagundi safety rules and to follow the instructions of the Mittagundi Directors and staff at all times.

Signed: _____ (Participant) Date: _____

ASTHMA FORM - Parent or Guardian to complete

Participants Name:

Usual maintenance medical program follow by the asthmatic:

Preventer medication: _____ Reliever Medication: _____

Peak Flow Readings: Best: _____ Critical: _____ (Bring own peak flow reader)

Medication and treatment to be used during an emergency asthma attack:

List of known Asthma Triggers: *(These may include food or food additives, insect bites, medications, plants or pollens, detergents, cleaning agents or others.)*

Key Questions:

Has asthma interfered with participation in normal physical activities within the past 12 months?	[] YES [] NO
Has the participant been admitted to hospital due to asthma in the past 12 months?	[] YES [] NO
Has the participant been on oral cortisone for asthma within the past 12 months (e.g. Prednisone, Cortisone, etc)?	[] YES [] NO
Has the participant suffered sudden severe asthma attacks requiring hospitalisation within the past 12 months?	[] YES [] NO
Does the participant require the use of a nebulising pump as a part of your regular or emergency asthma treatment?	[] YES [] NO

IMPORTANT NOTES:

If any of the "KEY QUESTIONS" 5, 6, 7 or 8 or 10 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 take this form to the Doctor with you.

DECLARATION

I declare that the information provided on this form is complete and correct and that I will notify Mittagundi if any changes occur. I give permission for Mittagundi to pass this information to a third party [eg Doctor, Hospital] to facilitate the medical treatment of my child (or myself for adults). I give permission for Mittagundi to retain this form in their archival program information, noting I can access it by appointment.

Signed: _____ (Parent/ Guardian) Date: _____

ALLERGY FORM - Parent or Guardian to complete

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.

Participants Name:

What is the participant allergic to?

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

Historically, has the participant suffered from:
 a **localised reaction** (rash, itching, swelling at the site the poison/irritant enters)
 a **systemic reaction** (rash, itching, swelling away from the site that poison/irritant enters)
 an **anaphylactic reaction** (severe breathing problem, generalised swelling, emergency situation)

Medication and treatment to be used during an allergic reaction:

Key Questions:

Have allergies interfered with participation in normal physical activities within the past 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the participant been admitted to hospital due to allergies in the past 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the person suffer a systemic or an anaphylactic reaction (see question 3 for definition), to their allergy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is there a history of anaphylaxis in the person's family?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the person take adrenaline (Epi-pen), when suffering an allergic reaction ?	<input type="checkbox"/> YES <input type="checkbox"/> NO

IMPORTANT NOTES:
If any of the "KEY QUESTIONS" 5, 6, 7 or 8 or 10 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 take this form to the Doctor with you.

DECLARATION

I declare that the information provided on this form is complete and correct. I further declare that if my child (or myself) is unable to self administer supplied medication, I give permission for trained Mittagundi staff to administer the supplied emergency medication. I give permission for Mittagundi to pass this information to a third party [eg Doctor, Hospital] to facilitate the medical treatment of my child (or myself for adults). I give permission for Mittagundi to retain this form in their archival program information, noting I can access it by appointment.

Signed: _____ (Parent/ Guardian) Date: _____

FITNESS TO PARTICIPATE FORM - MEDICAL OFFICER TO COMPLETE

Participants Name: _____ DOB: _____

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 run by Mittagundi are centered in a 'semi-wilderness' setting, meaning that professional medical care may be from 1 to 6 hours away. All programs involve physical exertion, namely, bushwalking (carrying an overnight backpack), river rafting/sledding, abseiling and walking around a sloping farm property; programs may also include camping, cycling, rock climbing or canoeing. We operate in all weather conditions.

Mittagundi staff hold a Wilderness First Aid qualification (minimum of 4 days training). This training is based on assessing and treating a patient in a remote or wilderness setting (for more information contact www.wmi.net.au).

Doctor's Section:

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

Should you require any further information on the program, please contact us at (03) 51510 7238.

Doctor's Name (Please Print): _____ Phone: _____

Signature of Doctor