

Group Number: _____

21-06-06

Maroon Outdoor Education Centre ADULT CONSENT AND MEDICAL FORM

SCHOOL:

PARTICIPANT'S NAME (IN FULL):

DATE OF BIRTH: RELIGION:

TELEPHONE: (HOME) (WORK)
(MOBILE)

MEDICARE NO: REF NO: EXPIRY DATE:

NEXT OF KIN

NAME:

ADDRESS:

TELEPHONE: (HOME) (WORK)
(MOBILE)

CONSENT

- **I am aware of the nature and scope of activities included in the program.**
- **I understand that programs conducted at Maroon OEC involve a high level of physical activity and are conducted predominantly out of doors.**
- **I understand that it is a 30 minute drive to Maroon OEC from the nearest ambulance, doctor or hospital and in some instances, the response time for medical attention may exceed 3 hours.**
- **I authorize the Principal or his representative to obtain such medical attention and transportation to medical attention as may be deemed necessary and I understand that I am responsible should any costs be incurred.**
- **I have advised the school's program co-ordinator, in writing, of my special dietary needs.**
- **I have completed the attached medical details and clearly outlined current medical information.**

Privacy Notice: Maroon OEC is collecting information on these forms in accordance with Education Queensland Policies for the purpose of ensuring the health and well being of individuals attending programs at the centre. These forms will be retained and held securely and will be disposed of when they are no longer required. Some or all of this information may be disclosed to Maroon OEC staff, school staff and volunteers, Qld Emergency Services Officers, Medical and Health Care Practitioners as deemed necessary. Personal information on this form may be disclosed where authorised or required by law.

For further information about EQ Privacy please contact Maroon OEC or your school.

SIGNATURE: DATE:

**PLEASE ENSURE THAT YOU COMPLETE THE MEDICAL INFORMATION FORMS
FULLY AND ACCURATELY**

MAROON OUTDOOR EDUCATION CENTRE ADULT MEDICAL INFORMATION

WHEN WAS YOUR LAST TETANUS BOOSTER?

SPECIAL DIETARY REQUIREMENTS:

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DO YOU SUFFER FROM ANY OF THE FOLLOWING?

If yes, please give full details - severity, medication, date of last attack / operation / injury.

(a) Asthma YES / NO

If YES, please complete an Asthma Management Form

(b) Other Respiratory Problems.....

(c) Drug Allergies.....

(d) Other Allergies (Food, plants, insects, animals) YES / NO

If YES, please complete an Allergy Reaction Management Form

(e) Diabetes YES / NO

If YES, please complete a Medical Management Form

(f) Epilepsy YES / NO

If YES, please complete a Medical Management Form

(g) Heart Problems YES / NO

If YES, please complete a Medical Management Form

(h) Blood Pressure

(i) Recent Operations/Injuries.....

(j) Swimming Ability Non Swimmer 25m 50m 100m

Give full details of any problems that might limit your full participation in any activity.

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List any prescribed medication that you are currently taking.

Drug Name	Dosage	Frequency	Doctors Instructions