

# HEALTH RECORD



## Health Record (This information will be kept confidential)

Name \_\_\_\_\_ Male / Female (circle one) Age \_\_\_\_\_ DOB \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Applicant's Blood Group (If known) \_\_\_\_\_

Medicare No. \_\_\_\_\_ Position \_\_\_\_\_ Other Health Care \_\_\_\_\_

Contact person in an emergency \_\_\_\_\_ Phone \_\_\_\_\_

Address of contact \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

If you answer "yes" to items 1-18, please supply full details on the lines below.

- |                        |            |                                  |            |
|------------------------|------------|----------------------------------|------------|
| 1. Heart Problems      | yes O no O | 2. Respiratory Problems          | yes O no O |
| 3. Travel Sickness     | yes O no O | 4. Phobias                       | yes O no O |
| 5. Operations          | yes O no O | 6. Recent Illnesses              | yes O no O |
| 7. Migraines           | yes O no O | 8. Blackouts                     | yes O no O |
| 9. Fits, Epilepsy, etc | yes O no O | 10. Asthmatic                    | yes O no O |
| 11. Diabetic           | yes O no O | 12. Restrictions on Activities   | yes O no O |
| 13. Bedwetting         | yes O no O | 14. Special Diet                 | yes O no O |
| 15. Disability         | yes O no O | 16. Medication Required          | yes O no O |
| 17. Drug Reactions     | yes O no O | 18. Allergies                    | yes O no O |
| 19. Can You Swim?      | yes O no O | 20. Last Tetanus Booster – Date: |            |

DETAILS: \_\_\_\_\_

### Authorisation and Agreement

In the event of accident or illness, I also authorise the Pathfinder Director to consent, where it is impractical or communicate with me, for me / my child to receive any x-ray examination, anaesthetic, medical, surgical or hospital treatment as may be deemed necessary by a licensed physician and/or surgeon. I also authorise to engage such treatment. I agree to pay the appropriate fees for such and any ambulance or other emergency transportation costs, which may be required.

I agree to meet the expense of me / my child being returned home, by the director or leaders. I understand that such an arrangement may be necessary due to illness, injury, or if, in the opinion of the Adventurer Director, non-cooperation of any description or the inability to meet the rigours and requirements of the activity.

I agree to me / my child attending the activity on this understanding.

Signed: \_\_\_\_\_  
Participant Date

Signed: \_\_\_\_\_  
Parent/Guardian (if applicant is aged under 18yrs) Date