RESILIENCE AND MENTAL HEALTH CAMP

MEDICAL AND PHOTO RELEASE FORM

JULY 2018

STUDENTS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YEAR LEVEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_\_\_\_

PRIMARY PARENT/ CARERS NAME (In Full): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE: (*HOME*) \_\_\_\_\_\_\_\_\_\_\_\_\_ (*WORK*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*MOBILE*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECONDARY CONTACT (In Case Primary Contact Cannot Be Reached)

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CIRLCE ANY OF THE BELOW CONDITIONS THAT YOUR SON/ DAUGHTER MAY SUFFER FROM:

* Asthma
* Other Respiratory Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Drug Allergies
* Any Other Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Anaesthetic Allergies
* Diabetic
* Epilepsy
* Blood Pressure
* Heart Problems
* Bed Wetting
* Recent Operations or Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Travel or Motion Sickness
* Special Dietary Requirements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YOU HAVE CIRCLED ANY OF THE ABOVE CONDITONS PLEASE EXPLAIN THE CONDITION AND ANY MEDICATION THAT IS REQUIRED TO BE TAKEN:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Note: (All Medication MUST be handed into the Camp First Aid Officer Before The Camp Begins to Be Checked Off – Some Medications Like Asthma Puffers Will Be Carried By The Student)*

NAME AND ADDRESS OF STUDENTS DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENTS MEDICARE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN WAS YOUR SON’S/DAUGHTER’S LAST TETANUS BOOSTER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAS YOUR CHILD BEEN IN CONTACT WITH ANY INFECTIOUS DISEASES IN THE PAST 3 MONTHS? YES/NO. IF YES, GIVE DETAILS BELOW:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHOTO RELEASE STATEMENT:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, herby give permission to Armed For Life for any and all photos and video material taken of my son/ daughter, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, on the Armed For Life Resilience and Mental Health Camp in April 2017 to be use by Armed For Life in any way they choose for marketing and promotion purposes.

I understand that I give this permission voluntarily and therefore will receive no payment for the photos or video material.

PARENT/ GUARDIAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/ GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_