MEDICAL INFORMATION

CHILD'S NAME: MEDICARE # EXP DATE:

If your child has ever suffered from the following conditions please provide the details below.

	CONDITION	**CIRCLE**	**PROVIDE DETAILS eg dates, severity, reactions, treatments**
1	Asthma or respiratory problems	Yes/No	If Yes, go to Asthma Management form
2	Allergies	Yes/No	If Yes, go to Allergy Management form
3	Heart condition	Yes/No	
4	Sight or hearing disorder	Yes/No	
5	Fears/phobias/bed wetting	Yes/No	
6	Diabetes	Yes/No	
7	Epilepsy	Yes/No	
8	Bleeding disorder	Yes/No	
9	Back, bone or joint problems	Yes/No	
10	Recent illness, injury or surgery	Yes/No	
11	ADHD/ADD	Yes/No	Please provide known behaviour and management strategies below
12	Aspergers	Yes/No	Please provide known behaviour and management strategies below
11	Medications required	Yes/No	Please provide details below. All medication is to be in original packaging, prescribed to the child and indicating dosage
12	Drug reactions	Yes/No	
13	Date of last tetanus injection	Yes/No	
14	Headaches, nose bleeds	Yes/No	
15	Swimming ability		(circle one) None Struggle Comfortable Strong
16	Special dietary needs		

PAIN RELIEF

Please label provided pain medication with your child's name; this will be held in safe keeping at Kiah Park and returned to your child at the end of camp. Pain medication will be administered and noted by a Kiah Park Supervisor.

FURTHER DETAILS OR OTHER CONDITIONS Please provide any other relevant information

ASTHMA MANAGEMENT PLAN **Only complete this section if your child has asthma**	
Name:	DOB:
Regular Medication:	Quantity or Daily Dose:
Additional Medication in case of attack:	Quantity or dose:
List of known trigger factors:	

Please note: Participant is to bring their medications as per medical form. Medications are kept in safe keeping and are administered by the under the management of a Kiah Park supervisor.

ALLERGENIC MANAGEMENT PLAN **Only complete this section if your child has an allergy**		
Name:	DOB:	
Allergy:	Signs or symptoms or reaction:	
List of medication used to prevent allergic reaction (if any):	Quantity or dose:	
List medication or treatment used if allergic reaction occurs:	Quantity or dose:	
Has the participant at any time in the past suffered from: ☐ A localized reaction (any rash/itching/swelling at the site of the allergen) ☐ A systemic reaction (any rash/itching/swelling away from the site of the allergen) ☐ An anaphylactic reaction (severe breathing problems, swelling of body, emergency situation)		
1. Does the participant suffer a systemic/anaphylactic reaction to allergy?	☐ Yes	☐ No
2. Is there a family history of anaphylaxis?	☐ Yes	☐ No
3. Has the participant been admitted to hospital for an allergic reaction?	☐ Yes	☐ No
4. Does the participant take adrenaline (Epi-pen) when suffering from and allergic reaction?	☐ Yes	☐ No
In case of an emergency I grant the person in charge at Kiah Park authority to seek any necessary medical assistance for my child. I give permission for camp staff to administer the supplied emergency medication if my child is unable to self-administer supplied medication. I declare that the information provided on this form is complete and correct. Name: (parent/guardian) _____ Signature: _____ Date:_____ Contact Mobile: _____ Landline: _____		