THAC v1.

Permission, Indemnity and Medical form (Under 18)

Personal Contact details:

Name of participant: _____ Date of Birth: / /

Residential Address: _____

Suburb/Town: _____ Postcode: _____

Mother's contact:

BH Ph: _____ AH Ph: _____

Mob Ph: _____ Email address: _____

Father's contact:

BH Ph: _____ AH Ph: _____

Mob Ph: _____ Email address: _____

Privacy information

- insert relevant details into the Privacy statement

Privacy Information

All the information recorded on this form is collected and managed in accordance with the THAC Privacy Policy.

If you do not want this information to be used for any other purpose other than THAC please notify us in writing:

Permission to participate in Program Activities:

I consent to my child/young person taking part in the approved program of activities for the (name group) which is attached/provided

Signed: _____Parent/Caregiver Date: _____

Emergency Contact:

Full name of person for contact in emergency: _____

Relationship to child/young person: _____

BH Ph: _____AH Ph: _____ Mob Ph: _____

Signed: _____Parent/Caregiver Date: _____

Additional information

Alternate Emergency Contact:

Full name of person for contact in emergency: _____

Relationship to child/young person: _____Phone: _____

BH Ph: _____AH Ph: _____ Mob Ph: _____

Signed: _____Parent/Caregiver Date: _____

Family Circumstances:

Are there any situations we should be aware of? Eg: Custodian Issues, Other maters. (please specify):

_____

If you are not able to collect your child – who may? _____

Permission for Transport

I give my permission for my child/young person to travel on public transport where this is specified in program activities.

Signed: _____Parent/Caregiver Date: _____

Consent specific for children and young people under 18 years of age

I give permission for my child to be transported in private cars by drivers who are approved by THAC.

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Please Tick ☑ □Yes □No

Choose elements that are relevant to activities
Confidential Medical Report:

Please tick ☑if any of the following apply

☐ asthma
☐ blackouts
☐ diabetic
☐ allergic reactions (eg bee stings, penicillin) _____

Additional
☐ heart condition
☐ migraines

☐ blood disorders
☐ blood pressure

☐ other;_____

Any special care required? (please specify): *e.g. (HIV, not to have blood transfusions, and treatments required, etc)*

_____

Are any medications being taken? ☐Yes ☐No

If yes, please state the name of the medication, dosage, etc

_____

If yes does your child self administer? ☐Yes ☐No

Details: _____

Last tetanus immunization: / /

Medicare No: _____

Medical/Hospital fund: _____ Membership No: _____

Name of family Doctor: _____ Ph: _____

Name of Dentist: _____ Ph: _____

Dietary Requirements**:** Please list any special dietary needs (include any food allergies):_____

_____

I, _____
authorise the leader in charge of the group, where it is impracticable to communicate with me, to arrange for medical treatment, as the leader may deem necessary at any time during the program activities. I further authorise the use of Ambulance and/or anaesthetic by a qualified medical practitioner if in his/her judgement it is necessary I accept responsibility for payment of all expenses associated with such treatment.
Please tick ☐ if you agree.

I understand that this information will be stored in a secure and confidential manner.

Signed: _____
Parent/Caregiver Date: _____
(if under 18 – parent/ legal guardian must sign)

Permission to be photographed or filmed
I give permission for my child/young person to be photographed and/or videotaped for the purposes of THAC. I understand that as a safety precaution my child's/young person's family name will not be published on the Internet and there will be no linkage of names with photographs.
Signed: _____*Parent/Caregiver* *Date:* _____