



QUEENSLAND BAND ASSOCIATION INC.

ABN: 60 795 850 027

PO Box 573 Lutwyche QLD 4030 - Web: <http://www.qba.org.au>

MED

MEDICAL DETAILS FORM (page 1 of 2)

Note: This form is to be completed fully and accurately for the safety of your child. (Please Print)

The information on this form will remain confidential and only available to camp organisers and approved qualified medical practitioners.

FULL NAME:	
ADDRESS:	
	D.O.B:
PHONE NO:	WORK NO:
EMERGENCY CONTACT PERSON:	
CONTACT NO:	MOBILE:
DOCTOR:	PHONE NO:

MEDICAL DETAILS

My child has a disability that may affect him/her <i>(Please circle one)</i>	YES		NO			
Details:						
<i>Please circle YES or NO for each relevant issue and if YES please give details below:</i>						
Heart problems	YES	NO	Diabetes	YES	NO	
Respiratory problems	YES	NO	Blood pressure	YES	NO	
Asthma	YES	NO	Recent Operations	YES	NO	
Other			Epilepsy	YES	NO	
Allergies to:	Food	YES	NO	Recent illness	YES	NO
	Drugs	YES	NO	Phobias	YES	NO
	Ointments	YES	NO	Bed Wetting (camp only)	YES	NO
	Insects	YES	NO	ADD/ADHD	YES	NO
Other:			Travel Sickness	YES	NO	
Details:			Sleep Walking (camp only)	YES	NO	
				Other:		
Dietary Requirements:						
Additional details:						
Has your child had a Tetanus booster in the last 12 months?						
			YES		NO	
Medicare Number:						
Name of Private Health Fund:						
Do you object to a blood transfusion? <i>(Please circle one)</i>			YES		NO	



MEDICAL DETAILS FORM (page 2 of 2)

DISCLAIMER

I hereby authorize the medical practitioner identified above to provide to hospital authorities or other qualified medical practitioners additional information concerning any of the medical conditions identified on this form should the need arise.

CURRENT PRESCRIBED MEDICATION

The medication/s listed below have been prescribed for my son/daughter by a registered medical practitioner and will be required to be administered whilst my child is involved in the camp and/or workshop. I hereby request the supervising tutor to administer the medication/s in accordance with the medical practitioner's instructions. I understand all unused medication will be returned to me.

Please complete the following. Rule a line through any unused spaces.

Name of Medication	Quantity of Medication	Times for Administration

AUTHORITY

I hereby authorise the supervising tutor to obtain any medical or associated assistance which they deem necessary should any medical condition or accident occur. I agree to pay any ambulance, medical, dental or pharmaceutical expenses incurred on behalf of the above which are not covered by my personal family ambulance subscription or medical benefits fund. Further, I authorise qualified practitioners to perform surgery, administer anaesthetic and/or administer blood transfusions if such an eventuality should arise. I understand, should such circumstances arise, the supervising Tutor will endeavour to contact the emergency contact identified above by phone in the first instance.

Name of parent/care provider (Please Print) _____

Signature of parent/care provider _____ Date ____/____/20____