SCOUTS AUSTRALIA – VICTORIAN BRANCH

PERSONAL INFORMATION RECORD

Please fill in the details with dark coloured ink

Scout Registration Number:

Working With Children Card Number:

Event: **Date/s of Event:**

NAME: Surname**:** ..... Given/ Preferred Name**:** .....

HOME ADDRESS: .....

Suburb: ..... Postcode: ..... Telephone No: .....

PERSONAL: Date of Birth: ..... Age at Activity: ..... Gender: Male ☐ Female ☐

Membership No: ..... Ancillary Benefits Cover: Yes

Medicare No: ..... Ambulance Ins Number: .....

Private Health Insurance: ..... Priv Health Ins Number: .....

DETAILS: **Scout**

....

SECTION GROUP DISTRICT REGION

EMERGENCY USE: Details of the Parents/Guardians where they can be contacted during the activity.

NAME: ..... Relationship: .....

ADDRESS: .....

Suburb: ..... Mother's Mobile: ..... Home: .....

Postcode: ..... Father's Mobile: ..... Business: .....

In an emergency, if we cannot contact you, whom else can we contact? Name & Relationship: ..... Phone: .....

HEALTH STATEMENT

If the participant suffers from any chronic or recurrent ailment, allergy or physical incapacity, it should be disclosed so that we are aware of the fact.

A	Does the participant suffer from any physical or other disabilities?	Yes / No	If yes, please specify: .....
B	Does the participant suffer from Asthma?..... Severe / Mild Diabetes? ..... Type 1 / Type 2 Epilepsy? ..... Severe / Mild Dizzy Spells or Blackouts? ..... Bed Wetting? ..... Sleep Walking? ..... Travel Sickness ..... Migraine Headache?	 Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No	Explanation/Medication: .....
C	Does the participant have any known **allergies**? ie Penicillin, bee sting, bites, egg, hay fever, other **food**, **drug** or other **environment** related allergy.	Yes / No	If yes, please specify: .....
D	Does the participant have any Medications on this activity? ie Injection/tablet/capsule Penicillin, insulin, Ventolin, other drugs	Yes / No	Name of Drug: ..... Dosage: ..... Reason or Cause: ..... How Often Administered: ..... Administered by Whom: .....

In the case of a Youth Member, please hand the medication – CLEARLY labelled with the child's name & dosage instructions – to the Leader in Charge of the Youth Member

E Is there **any further information** you may consider necessary, about which we have not asked above and of which we should be aware (including **special dietary requirements** Yes / No If yes, please specify: ……

……

F **Analgesics:** In the event of your child requiring the administration of an analgesic (eg Panadol), given the recommended child dosage of Paracetamol or Panadol? do you **HEREBY CONSENT** to your child being

Yes / No **If YES, please sign here:** .....

G **Details of last Anti-Tetanus injections:** Year of Original Injection ☐ Year of last booster injection ☐

I hereby **Authorise** the Leader in Charge of the above activity, in circumstances where it is not possible or it is impracticable to communicate with me, to seek for my child, such Surgical, Medical or Dental treatment as a qualified Surgeon, Medical or Dental Practitioner may consider to be necessary (including the transfusion of blood) and I hereby **Consent** to such treatment.

Date: ..... **Signed:** ..... **(Parent/Guardian)**

Form to be filled out by participant if over 18 years old, or by Parent/Guardian, taken to the event or handed to the Leader in Charge before you leave