PARICIPANTS MEDICAL INFORMATION

All information provided remains confidential and is required in case of emergency. The information you provide is relevant to those within the medical profession to take immediate action (if necessary) in the most effective and appropriate manner deemed necessary. This will also assist The L2P staff in contacting the families concerned. All personal information will be filed in accordance with the Privacy Act.

PARTICIPANT'S DETAILS

Full Name:

Address

Street | Suburb/Town | Postcode

Date of Birth: | Home Telephone: | Mobile:

EMERGENCY CONTACT DETAILS

Name | Relationship:

Address

Street | Suburb/Town | Postcode

Telephone: Home: | Work | Mobile:

Medicare Number | Private Health Cover + № | Concessional/Health Card Number

Family Doctor's Name | Clinic Name or Address: | Contact Tele:

MEDICAL HISTORY

Do you, as a participant have or had any of the following? Please tick those that are applicable.

☐ Asthma ☐ Diabetes ☐ Epilepsy

Allergy or Reaction to:

☐ Local Reaction ☐ Systemic Reaction ☐ Anaphylactic Reaction

Do you have an epi-pen? ☐ YES ☐ NO

If you have answered yes to any Medical Condition above, please submit a copy of your Medical Care plan. If there is any other Medical Condition we should be aware of, please inform us AS SOON AS POSSIBLE.

I declare that the information which I have provided on this form is complete and correct and I will notify the L2P staff if any changes occur. The L2P Program will not be held responsible for information that is incorrect or not provided as requested.

…… Participant's Signature

…… Guardian or Witness Signature

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