

Rotary Youth Enrichment Program (RYPEN)

2021 Application Form

Part B: Medical History

Camp Bornhoffen 9am Thursday 13th May – 1.00pm Sunday 16th May

The information requested on this form will be treated with strict confidentiality. It is to assist in the preparation of the seminar and in case of emergency be made available to person/s handling the treatment.

Applicants Name

Surname: _____ First Name: _____

Preferred Name: _____ Gender: M F (Please circle)

Date of Birth: _____ Age as of 1st May: _____

Emergency Contact Details

First name: _____ Surname: _____

Address: _____

Tel: h _____ w: _____ mobile _____

Email: _____

Relationship: _____

Health Care Details

Doctor's name: _____ Tel: _____

Dentist's name: _____ Tel: _____

Medicare Number: _____

Private Health Insurance (if applicable): _____

Ambulance Cover (please circle): Yes No

Immunisation Status

Are you fully immunised? Yes No (please circle)

Are your immunisations up to date? Yes No (please circle)

If partially immunised what are you immunised against?

Medical Details

Blood group _____ Do you object to transfusions? **yes / no** (please circle)

1. Allergies

Please list any allergies you may have: _____

Are you Anaphylactic: **YES** **NO** (please circle)

Treatment Plan : Please attach a copy of your current emergency plan with this application.

Please Note: If you are anaphylactic you are responsible for ensuring that you bring an epi-pen to the seminar with you, otherwise you will not be able to stay.

2. Food Intolerances

Please list any food intolerances you may have _____

Treatment for intolerances (special diets, medications etc) _____

Please list foods that cannot be eaten

3. Medical Conditions: Please answer this honestly to support your inclusion and participation in the seminar.

a) Please circle the **medical conditions** that may apply to you:

Asthma

Epilepsy

Diabetes

Anxiety

Dermatitis

Phobias

Treatment Plan: Please attach a copy of the treatment plan that includes the name, dosage and direction for administration of medication that is required whilst you will be at camp with this application

b) Please list any **physical/mental disability or behavioural challenges** that may apply to you (eg hearing impaired, Aspergers, Bi-polar, ADHD) _____

Treatment Plan: Please attach a copy of the treatment plan that includes the name, dosage and direction for administration of medication that is required whilst you will be at the seminar with this application.

ASD and behavioural challenges: Please attach a written overview with this application about triggers that may compromise your ability to participate and perform to your maximum potential whilst at the seminar (eg sensory, tactile triggers) and outline strategies that help coping with situations.

- c) **Other Medical Conditions/Information:** Please list any other health, medical details, not covered above, you want us to know about: eg. pending operations or any other health information that may be useful in the event of an illness or injury _____

Treatment Plan: Please attach a copy of the treatment plan that includes the name, dosage and direction for administration of medication that is required whilst you will be at the seminar with this application

Please Note: If you are on medication it is your responsibility for ensuring that you bring it with you to the seminar, and hand it to the First Aid Officer on arrival otherwise you will not be able to stay.

4. Hospitalisation

- a) Have you been hospitalised due to your medical condition? **yes** **no** (please circle)
- b) When and the duration of stay: _____

5. Further Information

Is there any other information that you believe is relevant either personal or medical that you would like to share? _____

Attendee Declaration:

I declare that the information provided on this form is true and correct.

Attendee Signature: _____ Date: _____

Parent /Guardian Declaration

I declare that the information provided on this form is true and correct.

Parent/Guardian Signature: _____ Date: _____

Administration Use Only

Medical Condition:	Emergency/ Treatment Plan received: yes no
Requires Medication: yes no	Requires Special Diet: yes no
Parent/Guardian Authorisation Signed: yes no	
Name of Committee member:	Date:

Parent / Guardian Medical Authorisation:

RYPEN is conducted and supervised by Rotarians, alumni and Friends of Rotary and their partners who live in with the participants. Strict rules will be enforced to ensure the safety and well-being of each participant. Accident insurance has been taken out for the duration of the seminar. We need your approval to **administer first aid and/or** seek medical assistance should an emergency occur.

Please sign below to give that approval.

I, _____ give permission for

- a) First aid to be administered
- b) medical assistance sought when required
- c) ambulance transport to be arranged

for _____ (name of applicant)

and I expect to be notified as soon as possible.

I agree to the above medical information provided being made available to first Aid officers, paramedics and medical practitioners if the circumstances warrant.

Parent/Guardian Signature _____ Date: ____

Confidentiality Statement

The **RYPEN** committee is committed to maintaining all personal information provided by the Awardees and their families in accordance with the Australian Privacy Principles. Procedures will be implemented to ensure that this information is protected and secure and remains confidential at all times. Information collected will be stored in a confidential manner and content will only be shared:

- ✓ on a need to know basis to maintain the health and well-being of the awardee while in attendance at RYPEN,
- ✓ with paramedics and doctors where emergency medical treatment is required