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3. REGISTRATION & MEDICAL CONSENT FORM

Privacy Notice: The Department of Justice and Attorney-General is collecting the information on this form to assist instructor/s to make informed program activity choices. The collection of this information is a condition for participation in Outlook programming and is part of the Outlooks' Risk and Incident Management procedures. The Department of Justice and Attorney-General usually gives some or all of this information to program staff, on call staff and in the event of an incident, emergency service personnel. Post program, information is securely archived by The Department of Justice and Attorney-General.

PROGRAM NAME: Cairns Climbing Club	**START DATE:** / / 2016 **FINISH DATE:** / / 2017
SPONSORING ORGANISATION: Cairns Climbing Club	

APPLICANT			
First Name:		Surname:	
Home Phone:		Other Phone:	
Address:			
Do you identify as an Aboriginal or Torres Strait Islander person?	Yes ☐	No ☐	
EMERGENCY CONTACT DETAILS			
Contact Person:		Relationship:	
Phone (home):		Phone (other):	
MEDICAL DETAILS			
Date of Birth: / /	Weight: kgs	Gender: Male ☐ Female ☐	Height: cms

Do you have, or have ever had, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Asthma ***If yes, date of last episode & any medication you use***	☐	☐	Heart Problems/ Disease	☐	☐	Diabetes	☐	☐
Drug Allergies *If yes, please circle* *Penicillin Morphia Other:*	☐	☐	High Blood Pressure	☐	☐	Bleeding Condition	☐	☐
Other Allergies ***If yes, please state***	☐	☐	Mental Health Issues	☐	☐	Recent Illness/Injury *If yes, please state*	☐	☐
Do you have any disabilities ***If yes, please state***	☐	☐	Fears/ Phobias *If yes, please state*	☐	☐	Other Conditions *If Yes, please state*	☐	☐

Current Medications: *list all medications you presently use -including prescription and over the counter medication*

Medication ____________ Dosage ________ Frequency ____________ Treatment for ____________

Medication ____________ Dosage ________ Frequency ____________ Treatment for ____________

Medication ____________ Dosage ________ Frequency ____________ Treatment for ____________

Parental Permission for Outlook staff to administer medication Yes ☐ No ☐

Are you currently pregnant? Yes ☐ No ☐ *If yes, how many months?*

Medicare No: ____________________ Place on card: Expiry date: / /	Private Health Fund *If Yes, please state details*
PARTICIPANT SIGNATURE:	**PARENT/GUARDIAN SIGNATURE:** *If participant is under 18yrs*
DATE:	**DATE:**

PARTICIPANT CONSENT - *All Participants to Complete*

I *(full name)*

Am consenting to participate in *(indicate name of program or activity)*
Cairns Climbing Club

- I understand that elements of the program are physically, socially and emotionally demanding.
- **I understand that certain risks and dangers will exist such as (but not limited to) loss or damage to personal property, injury or fatality.**
- I acknowledge that while the staff will make every reasonable effort to minimise risks, not all dangers associated with the activities can be foreseen. I accept the fact that, while the program staff are skilled and experienced, they can not guarantee my safety since some risks are beyond their control.
- I have a personal responsibility to follow safety guidelines established by program staff and I will inform them if I do not understand what is expected of me.
- I am sufficiently fit to participate in this program. I agree to notify the program staff of any changes to my health and fitness, which may occur before, or during the program. Should I become ill or injured, I give my consent to the program staff to provide or arrange for provision of medical treatment or rescue services as they see fit. I agree to pay for any such treatment or medical advice

SIGNED: **DATE:**

If participant is under 18 - PARENT / *GUARDIAN CONSENT

I *(full name)*

Of *(address)*

Phone *(home)* Phone *(other)*

Program Name

- I consent to my child's' participation in the above program. I understand that the nature of the program will involve risks. The staff undertake to use the utmost care in ensuring each participant has a safe environment to meet personal challenge. I understand that appropriate information will be provided to participants before they participate in the activity and that they may choose their own level of participation.
- I consent for the instructor-in-charge to obtain appropriate medical attention in the event of accident or illness and I undertake to pay for any such treatment or medical advice. I understand that I will be informed at the earliest reasonable opportunity.

SIGNED: **DATE:**

To be completed only if an agency is signing on behalf of a Parent or Guardian
Program Leader may sign on behalf of the legal guardian if:

- All reasonable steps to gain the consent of the participants Parents/Legal Guardians has been taken.
- To the best of their knowledge the parents/legal guardians would consent to their child's participation in the planned program.
- The Program leaders agency / Organisation accept full responsibility for the child's participation in the planned program.

Position of Person who has signed above: ____________________________________