



**ANNUAL HEALTH AND MEDICAL RECORD**

*The information below is requested to assist in case of any illness or accident and will be held in confidence*

**Known Allergies**

**General Information**

Name: .....

Date of Birth: ...../...../.....      Gender:  Male       Female

Address: .....

Phone (H): .....      Other: .....

Ambulance Subscriber:  Yes     No

Medicare No: .....

Name of Family Doctor: .....      Phone: .....

Name of Family Dentist: .....      Phone: .....

Date of last tetanus immunisation: ...../...../.....

Person(s) to contact in case of an emergency:

Name: .....      Name: .....

Relationship: .....      Relationship: .....

Phone: (H) ..... (M) .....      Name: (H) ..... (M) .....

Address: .....      Address: .....

.....      .....

.....      .....

**Please tick if your child suffers from any of the conditions listed below:**

- |  |   |
|--|---|
| <input type="checkbox"/> Epilepsy, convulsions, fits             | <input type="checkbox"/> Diabetes                             |
| <input type="checkbox"/> Vision Impairment                       | <input type="checkbox"/> Hearing Impairment                   |
| <input type="checkbox"/> Asthma                                  | <input type="checkbox"/> Back pain or spinal condition        |
| <input type="checkbox"/> High blood pressure                     | <input type="checkbox"/> Depression or anxiety                |
| <input type="checkbox"/> Low blood pressure                      | <input type="checkbox"/> Bleeding disorders (eg. Haemophilia) |
| <input type="checkbox"/> Skin conditions (eg. eczema/ psoriasis) | <input type="checkbox"/> Bed wetting                          |
| <input type="checkbox"/> Sleepwalking                            | <input type="checkbox"/> Migraines                            |
| <input type="checkbox"/> Travel sickness                         | <input type="checkbox"/> Dizziness/ Fainting                  |
| <input type="checkbox"/> ADD/ ADHD                               | <input type="checkbox"/> Cystic fibrosis                      |
- Other .....

Special dietary requirements .....

**Please list all prescription and over-the-counter medications your child is taking:**

MEDICATION	DOSAGE	FREQUENCY	REASON FOR USE

**Swimming Assessment**

Particularly during the summer months some Youth Group activities may include swimming or water activities. Knowing your child’s level of competency will greatly assist us. Please tick the most appropriate box:

- Non-swimmer                       Recreational swimmer                       Competitive swimmer

**In case of emergency**, I understand every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to the youth leaders, and/or licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalisation, anaesthesia, surgery, or injections of medications for my child. I accept responsibility for payment of all expenses associated with such treatment.

I have reviewed this entire medical form and have verified that all information is given fully and truthfully to the best of my knowledge. I also accept responsibility that if any of the above information should change over the course of one year it is my duty of care to contact the Southern Cross Youth Pastor to make him aware of any changes.

Name of Parent/ Guardian: .....

Signature: ..... Date: ...../...../.....