Bushwalking Leadership South Australia

Medical information & Acknowledgement of Risk

WalkingSA

Event: date/s:

PARTICIPANT DETAILS

Participant's Name:		Date of Birth:
Address:		
Phone Numbers: (H)	(M)	email:

EMERGENCY CONTACT DETAILS (While on program)

#1 Contact Name:		Relationship:
Phone Numbers: (H)	(M)	email:
#2 Contact Name:		Relationship:
Phone Numbers: (H)	(M)	email:

I _____ understand the nature of the activity and the risks in the activity. These include and are not exclusive to drowning, broken limbs, twisted & damaged joints through falling or being fallen on, animal bites including snakes, injury through exposure to weather, burns & cuts through stove use & other possibilities.

I understand anything I do on this event is my own responsibility. I understand I will not be forced to do anything I do not wish to do. I understand the nature of this training is to develop my skills beyond their current levels.

I understand that this activity may be cancelled or experience delays for weather & safety reasons.

I understand my obligations around covid 19, including social distancing,good hygiene and to not attend if showing any covid type symptoms. Further details: https://www.covid-19.sa.gov.au/ or get in touch.

I understand that I may be refused onto training programs (without refund) if not properly equipped or prepared.

In case of an emergency I allow appointed event/trip leader to take me for medical assistance by car, ambulance, or other emergency services vehicles at my expense. I allow First Aid to be administered by current Senior First Aid qualified designated people.

I have understood the activity and discussed any concerns with organiser and have clarified any areas of concern prior to signing this consent form. I have filled out this medical form honestly, and to the best of my knowledge.

Signature: _____ Name: _____ Date: ___ / ___ / ___

If under 18, legal guardian to sign

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Page 2: PARTICIPANT MEDICAL INFORMATION Date:

Name:

1. Are you covered by private health insurance?	**YES / NO**
Name of Fund: and policy number	
2. Are you covered by Ambulance subscription?	**YES / NO**
3. Medicare Number:	
4. Do you have / have you had asthma?	**YES / NO**
Trigger factors:	
Severity:	
Treatment / Medication:	
5. Do you have / have you had any allergies?	**YES / NO**
Trigger factors:	
Severity:	
Treatment / Medication:	
6. Do you require medication for any other conditions?	**YES / NO**
Name of medication:	
Reason for medication:	
When is it taken:	
7. Have you had any recent illness / surgery?	**YES / NO**
Details:	
8. Do you have any other medical conditions that may affect your participation	**YES / NO**
Details:	
9. Fitness Ability **POOR / FAIR / GOOD / EXCELLENT**	
10. Do you have any other conditions that may affect your participation?	**YES / NO**
Details:	