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|  **2017 Debutante Ball**  |
| **Medical Information** |
| The information requested will remain confidential and be used only for emergencies. |
| Name |  | Date of Birth |  |
| Medicare: |  | Healthcare: |  |
| **Medical History** |
| Does the young person have any disability or chronic illness or need any special health care? | ❒YES ❒NO If YES, please attach details and a management plan if applicable. | Special health care (please specify): |
| Is the young person taking any prescribed medication?  | ❒YES ❒NO If YES, Please specify what action is required: | Medication (please specify): |
| Does the young person have any of the identified health issues?  | ❒YES ❒NO If YES, please attach details and a management plan if applicable. | Health (please specify) |
| Does the young person have particular allergies? | ❒YES ❒NO If YES, Please specify what ,allergy and attach details and a management plan if applicable | Allergies (please specify): |
| Food allergies: Give any details of any special food requirements for medical, religious or other reasons. | ❒YES ❒NO If YES, please attach details and a management plan if applicable | Food Allergies (please specify): |
| **Emergency Contact** |
| Primary |  | Secondary |  |
| Name |  | Name |  |
| Relationship |  | Relationship |  |
| Contact number |  | Contact number |  |
| **Medical Consent** |
| In the event of an accident or illness and where I cannot be contacted, I authorise the Centre of Excellence, staff, and contractors to obtain the necessary emergency medical assistance required. |
| Guardian Name |  | Guardian Signature |  |
| Contact Phone Number |  | Date |  |
| Relationship  |  | *Organisation* |  |
| **Personal Consent- OVER 18** |
| Name |  | Date |  |
| Signature |  |  |  |