BELLARINE TRAINING AND COMMUNITY HUB INC
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DROP IN PROGRAM - MEDICAL FORM – CONFIDENTIAL

Name of participant _____ **DOB:** _____ **Age** _____

Address: _____

Next of Kin (for emergency contact): _____ **Relationship to participant:** _____

Emergency Contact numbers: Home: _____ **Mobile:** _____

Family Doctor: _____ **Phone:** _____

Blood group (if known) _____ **Date of last Tetanus injection:** _____

Health care card number _____ **Medicare card number:** _____

Ambulance Subscription Yes ☐ **No** ☐ **Private Health Care name:** _____**Membership number:** _____

Physical Condition	**Medication/frequency/relevant information needed for direct care of your child/guardian (please add a page if required)**
ADD/ADHD	
ASTHMA (please attach asthma plan)	
AUTISM (please list triggers and provide information required care.	
Allergies (please specify) Hay fever ,Food, Medical Other	
Back problems	
Blood nose(s)	
Bones (please include breaks and dislocations)	
Epilepsy	
Eye/Optical problems	
Fainting	
Heart conditions	
High Blood Pressure	
Migraines	
Hearing problems	
Other medical conditions (please list or attach another sheet)	
Mental Health/Wellbeing	
Depression/anxiety or other psychological problems	
Any other personal, family situation, court orders or wellbeing concerns that might be beneficial for the OGNC youth workers to be aware of when caring for your child/guardian **(please attach another sheet if required or mental health plans if available)**	

Signature of parent/guardian _____ **Date** _____

PRIVACY: Bellarine Training and Community Hub acknowledges and respects the privacy of individuals. The information collected on this document is confidential and may only be disclosed in the case of a young person requiring medical attention. You have the right to access and alter personal information concerning you in accordance with the Information Privacy Act (2001) and the Health Records Act (2001).