Medical Details and Dietary Requirements Information Form

IGSSA Sporting Tour – 2018

Destination : China / Singapore (please circle Tour)

Please take the time to carefully read and complete this six page form (only complete pages 5 and/or 6 if necessary), and include any extra information you feel is relevant to your daughter's health and well-being whilst on this tour.

Daughter's name (as on passport): _____

Medicare number: _____ Expiry date: / Line Number: _____

Private Health Company: _____ Card Number: _____

Parent Name/s: _____

Emails: _____

Address: _____ P/C : _____

Parents' telephone 1. (mb) _____ 2. (mb) _____

3. (hm) _____

Student's Mob Phone: _____

Additional emergency contact for duration of trip:

Name: _____

Relationship to daughter: _____

Phone numbers: Hm _____ Mb _____

Passport Number (must be current): _____

Passport Country of Origin : _____

Passport Expiry (must have 6 months **past** return date of 22nd April): _____

If your passport expires before 22 Oct, 2018 – please apply for a new passport now!

Special Dietary Requirements and Other Specific Allergies

Special Dietary Requirements (eg Religious / medical) _____

_____

_____

*Other specific Allergies _____

_____

_____

_____

_____

* The allergy Management form will need to be completed for any Allergies reported (page 5)

Other Medical Information

Does your daughter experience any of the following medical conditions? (Please tick the appropriate box):

	YES	NO	Details. **If necessary, please add extra information on bottom of this form.**
*Asthma – *see page **4***			
*Allergies (eg: medication, stings, foods, etc) – *see page **5***			
Diabetes			
Epilepsy			
Heart/Lung complaints			
Joint/bone problem/s (past & present)			
Migraines			
Phobia/s			
Eating disorder			
Blood disorder/s			
Psychological condition/s eg ADHD, ADD, Anxiety			
Sight/ Hearing problem/s			
Sleepwalking			
Travel sickness			
Hay fever			

Blood Group (if known) _____

Will your daughter be taking **any** medicines, tablets, inhalers etc with her? YES / NO
If YES, please provide details (see table below)

Will there be a need to assist with the management or administration of this? YES / NO
Staff may be required to carry / administer some medications. You will be notified if this is required.

Medical Condition	Medication	Dosage	Further Details. eg: must be kept in refrigerator

Additional Information Space

_____

_____

_____

_____

Immunisation Record

Please note that you may be required to update your vaccines prior to departure when travelling overseas on your tour. **Please consult your local GP or Travel doctor well in advance of your child's departure date.**

Immunisation/Vaccination	Last Updated
Meningococcal	
Chicken Pox	
MMR	
Measles	
Mumps	
Rubella	
HIB	
Poliomyelitis	
Yellow Fever	

Immunisation/Vaccination	Last Updated
DTP	
dTpa (DTP booster)	
Diphtheria	
Tetanus	
Whooping Cough	
Cholera	
Hepatitis B	
Hepatitis A	
Influenza	
Typhoid	

Do you give consent for your daughter to be administered the following whilst on tour?

Paracetamol: ☐ Yes ☐ No

Ibuprofen/ Anti-inflammatory (eg Nurofen): ☐ Yes ☐ No

Non-drowsy antihistamine (eg Claratyne): ☐ Yes ☐ No

Can your daughter swim 50 Meters? ☐ Yes ☐ No

Swimming ability: ☐ Weak ☐ Average ☐ Strong

***If you answered 'YES' to Asthma, the Asthma Management form MUST be completed (Pg 5)**

***If you answered 'YES' to Allergies the Allergy Management Form MUST be completed (Pg 6)**

Authority to obtain Medical Treatment

I authorise the staff of IGSSA in the event of accident or illness of my daughter to obtain any medical assistance or treatment, including administration of an anaesthetic, which they may consider necessary and, for this purpose, engage any doctors, nursing assistance or hospital accommodation.

In this event I agree to pay what is not covered by the Travel insurance or our Personal Health Insurance
I understand that in the event of any such accident or illness, every effort will be made to contact me.

I have noted on the Medical Form all medical information of which the staff member in charge should be aware including the telephone numbers which would be relevant at the time of the visit. I understand that all this information is confidential, but I permit this information to be passed on to a third party to assist in the correct medical treatment of my child.

I declare that the information provided on this form is complete & correct & that I will notify IGSSA if any changes occur. I give permission for IGSSA to retain this form in their archives, which I can access by appointment.

Name of Parent _____

Signature of Parent _____ **Date:** _____

Once completed, please scan & email to Louise Carson (louise@igssa.org.au), or post to
IGSSA
PO Box 25
Mt Lawley, 6929

IGSSA Tour **Asthma Management Form 2018**

Surname: **Given names:**

- **IMPORTANT INFORMATION FOR PARENTS:** It is essential that we have a good understanding of your child's asthma in order to be able to assess the risk associated with different activities to your child & also to be able to offer the best possible assistance should an attack occur. **For this reason, we require that all participants who suffer from Asthma should complete the following questions.** You may require the assistance of your doctor to complete this.

TO BE COMPLETED BY THE PARENTS

Please list the person's usual management plan for their asthma:_____
_____
_____
_____
Preventer - _____
Reliever - _____
Peak Flow Readings - Best:_____ Critical:_____ (Please bring Peak Flow Meter)
Medication & treatment to use during a severe asthma attack - _____
_____
_____
_____
Where is the medication located?_____
Any known trigger factors?_____
_____

Please ensure you pack enough medication for the duration of the programme. Please do not change the medication your child is on or the dosage required – this could affect their participation levels.

FIVE KEY QUESTIONS

(Please tick the appropriate box)

1. Has the participant been ***hospitalised*** or required ***emergency medical attention for their asthma in the past 12 months?*** □ Yes □ No
2. Has the participant required oral cortisone (eg-Cortisone, Prednisone) for asthma ***in the past 12 months?*** □ Yes □ No
3. Does the participant ***wake regularly*** at night due to their asthma? □ Yes □ No
4. Has asthma interfered with participation in physical activities ***in the past 12 months***? □ Yes □ No
5. Does the participant ***regularly require a nebuliser*** as part of their ***routine*** asthma treatment? □ Yes □ No

I declare that the information provided on this form is complete & correct & that I will notify IGSSA Staff if any changes occur. I further declare that if my child is unable to self -administer supplied medication, I give permission for IGSSA staff to administer the supplied emergency medication. I permit this information to be passed on to a third party to assist in the correct medical treatment of my child. I give permission for IGSSA to retain this form in their archives, which I can access by appointment.

Name:_____Signature:_____Date:_____

IGSSA Tour **Allergy Management Form 2018**

Surname:	**Given names:**
What is your child allergic to?	

IMPORTANT INFORMATION FOR PARENTS

A severe allergic reaction is a potentially serious condition. Both you and your child should have a good understanding of the severity of the allergic reaction and the trigger(s) of this reaction. It is essential that we also have a good understanding of your child's condition in order to be able to assess the risk associated with the different environments in which they will find themselves and also be able to offer the best possible assistance should a severe allergic reaction occur. **PLEASE ENSURE A DOUBLE DOSE (2) OF ALL MEDICATION (UNEXPIRED), *INCLUDING EPIPENS*, FOR THIS ALLERGY(S) IS TAKEN ON TOUR & NOTED ON THE MEDICAL FORM. PLEASE RETURN THIS FORM TO IGSSA.**

MANAGEMENT & TREATMENT

1. What are the signs and symptoms of the persons' reaction?

2. What are the trigger factors for an allergic reaction?

Insect stings / bites	□ Yes	□ No	Please specify_____
Food	□ Yes	□ No	Please specify_____
Drugs	□ Yes	□ No	Please specify_____
Physical Factors (eg, cold)	□ Yes	□ No	Please specify_____
Other	□ Yes	□ No	Please specify_____

If the allergen is a FOOD, is the allergy triggered by:

INGESTION ☐ ***SKIN CONTACT*** ☐ ***GENERAL EXPOSURE (e.g., particle inhalation)*** ☐

3. ***If the allergen is a FOOD, can your child's level of sensitivity tolerate this food being prepared, cooked & consumed by other members of their group in close proximity?*** □ Yes □ No

4. What medication (if any) does the student take for ***prevention or treatment*** of an allergic reaction?

5. Historically, has the participant suffered from?

□ A **localised reaction** (rash, itching, ***swelling at the site*** the allergen enters)

□ A **systemic reaction** (rash, itching, ***swelling away from the site*** the allergen enters)

□ A **systemic reaction** (***severe breathing problems***, total body swelling, an emergency)

DO NOT ANSWER THESE 5 QUESTIONS IF YOUR ALLERGY IS TO A PRESCRIPTION MEDICATION

FIVE KEY QUESTIONS

Please answer by marking the appropriate box

1. Have allergies interfered with participation in physical activities ***in the past 12 months?*** □ Yes □ No
2. Has the participant been ***hospitalised*** due to an allergic reaction ***in the past 12 months?*** □ Yes □ No
3. Has the participant suffered a **systemic or anaphylactic reaction** (see description above) to their allergen(s) when exposed to it/them ***in the past 10 years?*** □ Yes □ No
4. Is there a family history of anaphylaxis? □ Yes □ No
5. Does the participant use adrenaline (Epi-pen)) when suffering an allergic reaction? □ Yes □ No

I declare that the information provided on this form is complete & correct & that I will notify IGSSA if any changes occur. I further declare that if my child is unable to self -administer supplied medication. I give permission for IGSSA staff to administer the supplied emergency medication. I permit this information to be passed on to a third party to assist in the correct medical treatment of my child. I give permission for IGSSA to retain this form in their archives, which I can access by appointment.

Name:_____Signature:_____Date:_____