

INFORMATION ON THIS FORM WILL BE AVAILABLE TO BY LEARNING ADVISORS INVOLVED IN THE TRIP. PLEASE ADD ADDITIONAL INFORMATION IF NECESSARY AND DISCUSS ANY HEALTH OR OTHER TRIP RELATED CONCERNS THAT MAY BE RELEVANT WITH LA'S INVOLVED IN THE TRIP

Student Name:		Please return this form to school by:	/ /
Trip:		Learning Advisor	

<b>1. Please tick if the participant experiences any of the following:</b> Migraine <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Travel Sickness <input type="checkbox"/> Chronic nose bleeds <input type="checkbox"/> Colour blindness <input type="checkbox"/> Heart condition <input type="checkbox"/> Sleepwalking <input type="checkbox"/> Anxiety <input type="checkbox"/> Bed-wetting <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Asthma <input type="checkbox"/> Fits (any type) <input type="checkbox"/> Other (please specify)	<b>2. Is the Participant currently taking medication?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If YES, please state: Name of medication: Dosage and time to be taken: Ailment(s) and/or Other treatment(s)	<b>4. Is the Participant allergic to any of the following?</b> Allergy <input type="checkbox"/> Please specify Medication <input type="checkbox"/> Food <input type="checkbox"/> Insect bites /stings <input type="checkbox"/> Other allergies <input type="checkbox"/> What treatment is required?
	<b>3. Has the Participant had any major injuries (breaks or strains) or illness (glandular fever etc) in the last six months that may limit full participation in any activities?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If YES, please state the injury/illness:	<b>5. Is the Participant's tetanus injection up to date?</b> Yes <input type="checkbox"/> Date: No <input type="checkbox"/> Does not have tetanus injections. <input type="checkbox"/>

<b>6. Outline any dietary requirements:</b> Vegetarian <input type="checkbox"/> Vegan <input type="checkbox"/> Other <input type="checkbox"/>
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<b>7. What pain/flu medication can the participant be given if necessary? Please state:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>8. To the best of your knowledge, has the participant been in contact with any contagious or infectious diseases in the last four weeks?</b> If YES, please give brief details	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>9. Is there any information the staff should know to ensure the physical and emotional safety of the participant? (For example cultural practices; disability; anxiety about heights/darkness/small spaces; pregnancy; behaviour or emotional problems).</b> If YES, please state or attach the information.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Please read the following and initial if you, the Parent/Caregiver/Adult Participant, agree to these expectations	Please Initial
I also agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened and handed to the designated adult with instructions on its administration.	
I will inform the school as soon as possible of any changes in the medical information or other circumstances between now and the commencement of the event.	
I agree to my daughter/son myself receiving any emergency medical, dental, or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.	
Any medical costs not covered by ACC or a community service card will be paid by me.	

**This Health Profile is to be read, completed, and signed by a parent/caregiver of student participant, or by the adult participant (LA included):**

Print name		Date	
Signed		Medic Alert number (if applicable)	