Participant Medical Disclosure Form

Thank you for completing this form so your young person can experience Operation Flinders! If you have any questions, please contact your School/Agency's Coordinator.

NOTE: Please read each section thoroughly and complete it as fully and honestly as possible. Failure to provide detailed information can make it difficult to provide the appropriate care for the young person concerned.
If you are unsure how to answer any of the questions, please consider taking the form to your GP for assistance.

Participant Preferred Name (optional)

First Name Last Name

Participant Information

Participant Legal Name *

First Name Last Name

Which of the following most accurately describes the participant? *

- ☐ Female
- ☐ Male
- ☐ Non-Binary / Gender Expansive
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Prefer not to answer

Prefer to self describe:

What are the participants pronouns? This helps us understand the best way to address / communicate with them.

- ☐ She/her
- ☐ He/him
- ☐ They/them
- ☐ Prefer not to say
- ☐ Unknown

Let me type...

Participant Date of birth *

Day Month Year

School/Agency *

Participants height (cm) *

Participants weight (kg) *

Medical Information

Medicare Number: *

Health Care Card Number:

If applicable

Private Medical or Health Fund:

Membership number:

If applicable

General Health

	Yes	No	Unsure
Has the participant been immunised against tetanus in the last 10 years?	○	○	○

Does the participant have, or have they ever had, any of the following conditions?

	Yes	No
Psychological/behavioural concerns	○	○
Diabetes	○	○
Allergies, e.g., foods, bee stings, certain drugs	○	○
Head injury or concussion	○	○
Migraine or severe headaches	○	○
Fainting spells or blackouts	○	○
Convulsions, fits, or epilepsy	○	○
Vertigo or claustrophobia	○	○
Asthma/breathing difficulties	○	○
Heart or circulatory disorders	○	○
Arthritis or rheumatism	○	○
Anaemia	○	○
Bleeding problems	○	○
Digestive problems	○	○
Kidney or bladder problems	○	○
Injury to any joint or bone	○	○
Spinal injuries or disorders	○	○
Sinus problems	○	○
Speech difficulty	○	○
Eye disease	○	○

Visual impairment	○	○
Ear disorders or hearing difficulties	○	○
Skin disorders, e.g., eczema, tinea	○	○
Recent injuries or operations	○	○
Any other condition not listed above	○	○

If you answered YES to any of the above, please provide as much detail as possible below. List the dates of the illness/problems, and the current effects of any condition. Please include whether any current or past condition might be of concern during the Exercise. Provide additional detail via email to your referring agency coordinator if required.

Allergy Information: please tick all that apply *

- ☐ None
- ☐ Eggs
- ☐ Wheat/Gluten
- ☐ Peanuts
- ☐ Tree/other nuts
- ☐ Shellfish/Seafood
- ☐ Dairy
- ☐ Soy
- ☐ Medications (please provide details below)
- ☐ Other (please provide details below)

Other allergy not listed above (or further details)

For participants with asthma:

When was the participants last asthma attack?

How often does the participant have asthma attacks?

Has the participant ever been hospitalised with asthma? If so, when?

What factors induce the participants asthma?

Operation Flinders recommends that participants who have any concerns about their asthma obtain an Asthma Management Plan from their medical practitioner.

Medication

Please note, that Operation Flinders volunteers are not responsible for carrying or administering your young person's medication. The school/ referring agency support staff will carry out this duty.

	Yes	No
Has the participant received any significant drug treatment in the past 5 years?	○	○
Is the participant regularly or currently taking ANY medicine, tablets, injections or other medications?	○	○
Will the participant be bringing any medicine, tablets, inhalers etc. on the program? If YES, see note above.	○	○

For participants with psychological or behavioural concerns:

Does the participant have any particular behavioural concerns?

- ○ Yes
- ○ No

Has the participant been diagnosed with a mental health condition? If so, what?

If they have been diagnosed with a mental health condition, have they seen a psychiatrist, psychologist, or counsellor?

- ◯ Yes
- ◯ No

Has the participant been on medication for the above condition? If so, please detail in the next section.

- ◯ Yes
- ◯ No

General Agreement

At Operation Flinders, the following non-prescription medications are routinely administered for medical issues (only when deemed appropriate by a registered paramedic):
- Paracetamol (for sprains, headaches, low grade fever)
- Ibuprofen (for sprains, headaches, swelling)
- Antihistamine (for hayfever, allergies)
- Ventolin (for asthma, breathing difficulty)

I have read and agree to the above *

- ◯ Yes
- ◯ No, provide detail below

If you DO NOT want any of these medications to be administered, please tell us which ones and provide further detail.

Do you give permission for the Qualified Exercise Paramedics to treat the participant for any medical or trauma episode if you are not contactable, or we are unable to make contact? *

- ◯ Agree
- ◯ Can someone contact me to discuss this further

As the participant's parent/guardian/caregiver, you acknowledge that you have provided the most accurate medical history possible. *

- ◯ Agree
- ◯ Can someone contact me to discuss this further

Date *

Day Month Year

Name of the person completing this form *

First Name Last Name

Referring agency coordinator use only

Submit

Name of the person who is submitting this form online on behalf of the above-named person (who completed it in hardcopy format)

First Name Last Name

Submit

Date

Day Month Year