MEDICAL DISCLOSURE FORM *without prejudice*

YOUR NAME ……

Personal medical information you provide on this form may help you in the unlikely event of an injury or illness requiring medical assistance. While our staff are qualified to provide first aid, they are not doctors. In case of incident, staff may need to leave you to call for further help. Therefore, it is important to disclose particular details that YOU would want staff, rescue workers, ambulance officers and doctors to know about you.

Your medical information will be held in confidence and will only be used to help staff, rescue and medical officers respond to an injury, accident or medical emergency. Your medical information will not be disclosed to others. The form is to be held by the trip leader and will be returned to you after the activity or destroyed.

It is not our intention to exclude you from any activity because of your answers; in some cases we may counsel you as to the risks for both you and others in the group. If you are concerned about your fitness for the activity, please discuss with your trip leader.

DISABILITY: It may be best for those requiring a carer to ask for *Access Tourism*.

GENDER male/female AGE ……..(years) Date of birth ……./……./……

BLOOD TYPE …….. Height …….cms Weight ……kg BMI ……

Home address ……

…….. Home telephone (……)……

IN CASE OF EMERGENCY PLEASE CONTACT

Name …… Relationship ……

Address ……

……..Telephone (…...)……
OR
Name …… Relationship ……

Address ……

……..Telephone (…...)……

Usual doctor …… Telephone (……)…..……..

Address……..

Other medical specialists ……...Telephone (…….)……

Address ……

Medicare number (if applicable)……Hospital insurance YES/NO

If “yes”, name of insurer …… Policy number …….

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IMMUNISATIONS Please indicate year of immunisation for each of the following:
Polio…….. Smallpox…… Typhoid……. Hepatitis…….. Meningococcal……. Mumps…….
Measles…….For Tetanus, please give actual month and year: ……(m) ……(y)

Do you wear glasses? YES/NO Contact lenses? YES/NO Hard/soft Dentures? YES/NO

PLEASE LIST ALL INFORMATION REGARDING THE FOLLOWING:

Are you under treatment for any illness or condition? YES/NO If "yes", please give details:

……

……
Are you currently taking any form of medication? YES/NO If "yes", please give name, dosage and frequency and any side effects.

……

……
Do you have any allergies? YES/NO
If "yes", please give details (foods, bites, stings, medications e.g. penicillin or anaesthetic)

……
Do you have any disabilities? YES/NO If "yes", please give details. *Note: it may be possible to to accommodate some disabilities*. But please discuss with your leader/s before caving.

……
Do you have any previous injuries? YES/NO If "yes", please give details.

……
Do you have any history of heart problems? YES/NO If "yes", please give details.

……
Have you ever undergone surgery? YES/NO If "yes", please give details.

……
Please circle or list any serious or chronic ILLNESSES or CONDITIONS you have had and give the YEAR(s) of occurrence.

Arthritis	Heart disease	Poliomyelitis	Chest pain
Asthma	Hepatitis	Rheumatic fever	
Convulsions	Malaria	Tuberculosis	OTHER (list):
Diabetes	Meningitis	Typhoid	
Epilepsy	Pleurisy	Ulcer	

Please circle the INJURIES you have had and give the location and year.

Back pain	Concussion	Dislocation	Fracture
Hernia	Sprain	Strain	OTHER:

Please circle any of the following CONDITIONS you have had and give the year of occurrence.

Blackout	Dizzy spells	Headaches	Menstrual cramp
Chronic cough	Stomach/digestive problem	High blood pressure	Muscle cramp

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