

Western District Health Service

PARTICIPANT INFORMATION FORM (For young people aged 11 – 18 years)

SCHOOL HOLIDAY PROGRAM

Participant details

Participants full name: _____

Address: _____ Town: _____ Postcode: _____

Childs mobile: _____ Email: _____

Date of Birth: ___/___/___ Male Female Indigenous: Yes No

Activity information

Date	Activity	Location	v activity	Price	Office use
Monday	Learn to Surf	Pt Fairy	<input type="checkbox"/>	\$35	<input type="checkbox"/>
Tuesday	Shopping Tour –DFO – Vic Market – Harbour Town	Melbourne	<input type="checkbox"/>	\$35	<input type="checkbox"/>
Wednesday	Paintballing	Mt Gambier	<input type="checkbox"/>	\$35	<input type="checkbox"/>
Thursday	Rampfest	Melbourne	<input type="checkbox"/>	\$35	<input type="checkbox"/>
Friday	Adventure Park	Geelong	<input type="checkbox"/>	\$35	<input type="checkbox"/>

Medical information

Swimming ability: Non swimmer 25 – 50m 50 – 200m 200m +

Ambulance cover: Yes No Healthcare card: Yes number: _____

Private Health fund name: _____ Member No: _____

Medicare No: _____ Tetanus: Yes No Year of immunisation: _____

Asthma Travel illness Hearing loss Vision loss Epilepsy

Diabetes Aspergers Autism ADHA/ ADD other: _____

Please provide further information on **conditions, allergies or dietary requirements:**

You must provide an Action plan with a current photo attached for any child suffering from any major allergies or asthma. Due Friday 13 December via email, fax or post

Contact information

Parents/ guardian full name: _____

Ph (H): _____ (M): _____ (W): _____

Emergency contact: _____ Relationship _____

Ph (H): _____ (M): _____ (W): _____

Case manager (if applicable) Name: _____

Agency: _____

Ph (W): _____ **(M):** _____

Authorisation

I give permission for my child's image to be taken while involved on this program, and for such images to be used for publications by Western District Health Service (WDHS).

I agree that WDHS will not incur any responsibility or liability for any accident / injury / damage to / loss of property of the applicant during the program. I further authorise to obtain medical/ambulance assistance in the case of emergency involving the applicant. I understand that I must disclose any injury or medical conditions of my child and if my child requires prescription medications they must be capable to self administer.

I understand that inappropriate behavior, including: bullying; harassment; illegal activities e.g. willful damage of property and theft; disrespect for authority and other participants; use of drugs or/ & alcohol will result in immediate exit from the activity. Nominated guardian will be phoned to arrange collection of my child from activity

Parents/ guardian full name: _____

Signature: _____ Date: ___/___/___

Payment Details

Pay by: Cash Cheque Visa MasterCard

Cardholder's Name: _____

Card Number: _____

Expiry Date: ___/___ Amount: \$ _____ Cardholders Signature: _____

Office Use Only

Staff Member: _____ Date: ___/___/___ Amount received \$ _____

Receipt no: _____ Payment Form: Cash Cheque Eftpos Invoice