



CHILD REGISTRATION & U18 MEDICAL & PERSONAL INFORMATION

It will be great to see your child join in the activities we have planned. In order for us to provide the best level of care while your child is under our supervision, we require that you fill out and return the Registration/ Medical form below.

Protecting your privacy is important to us. The information we seek allows us to manage risk, provide reasonable care and administer your involvement in our program. We are careful to keep your information confidential, and provide it only to those agents acting on behalf of the organisation who need it to enable them to perform their agreed activities (e.g. the First-Aider-In-Charge)

Program: **XTREME KIDZ - Torquay Salvation Army**

Personal Contact Details

Child's Given Name _____ Surname: _____

Preferred Name _____ Male Female Date of Birth: _____

Address _____

Suburb _____ Postcode _____ Phone () _____

Do you consent to appropriate use by us of photographs taken on the program that include your child? For example, inclusion in our newspaper, placement on our web page or in a brochure Yes No

Program Preparation Details Dietary Requirements:

Does your child have any special dietary requirements? Yes No

If so, please list them: (We will endeavour to meet these requirements, and will contact you if necessary)

Tick which days you are planning for your child/children to attend: (See Flyer) BLITZ PROGRAM– during School Holidays Sunday – Extreme Kidz Live 11am - 12noon Monday - XTxtreme Kidz Club 3:30pm-5:30pm

Do you permit your child/ children to leave the program unattended? Yes No

Family Email Address—to notify of changes/ updates to program - _____

Safety and Care Details

In case of an emergency, please list phone numbers where you and a friend or relative may be contacted during the course of the program.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

Permission for the use of Band-aids – do you give permission for your child to be given a bandaid/s by an XTreme Leader should the need arise? (for allergy purposes)

Yes No

Information on Relevant Conditions

Are there any conditions which require special attention that we should know about, e.g. hearing or sight impairment, ADD or ADHD, behaviour issues, formal counselling situations, or any other? Please list below:

Please Turn Over Page



Medical Information

Please give details of your child's medical insurance if applicable
Insurance Provider: _____ Membership Number: _____
Medicare Number: _____ Number of person on Medicare Card: ____ Expiry Date: _____
Do you have ambulance cover? Yes No Health Care Card Number (if applicable): _____

Important: Please note that in regards to non-prescription medications such as paracetamol (e.g. Panadol), it is our policy that leaders team members do not provide medications.

Will your child need to take any tablets or other medication during the course of the program? Yes No

If yes, please give details: _____

Has your child been taken off medication recently? If yes, please give details? Yes No

What is the year of your child's last tetanus injection? _____

Has your child previously broken/fractured any bones? If Yes, please give details: Yes No

Specific Medical Conditions

Please indicate if your child has had any of the conditions below. Provide additional details if necessary.

Condition	In the Past	Present	Details: e.g. severity, last injection, treatment	Condition	In the Past	Present	Details: e.g. severity, last injection, treatment
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>		Hypo activity	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>		Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	
Fits/Convulsion	<input type="checkbox"/>	<input type="checkbox"/>		Allergy – foods	<input type="checkbox"/>	<input type="checkbox"/>	
Faint/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>		Allergy – animal	<input type="checkbox"/>	<input type="checkbox"/>	
Glandular Fever	<input type="checkbox"/>	<input type="checkbox"/>		Allergy – other	<input type="checkbox"/>	<input type="checkbox"/>	

Particular Activities

In attending the program, you consent to your child's participation in a range of general sporting and recreational activities. If potentially risky activities of a specific nature are included, the Team Leader will inform you of these.

Are there any specific activities that you do not wish your child to participate in? Yes No

If yes, please specify: _____

Your Agreement with the Organisation

I am aware, in signing this document regarding my child's participation this program, that certain elements of the program could be physically and emotionally demanding. Furthermore, I understand that certain inherent risks and dangers may exist in the activities in which my child will be participating. I acknowledge that while the organisation and its leaders will make every reasonable effort to minimise exposure to known risks, all hazards and dangers associated with these activities cannot be foreseen or may be beyond the control of the organisation, its leaders and staff. In the event of any emergency where my nominated contact people are unavailable:

1. I authorise the leaders to obtain medical advice and/or assistance which they deem necessary.
2. I further authorise qualified practitioners to administer anaesthetic if required.
3. I accept all operation, blood transfusion and/or anaesthetic risks involved in the event that such procedures are deemed necessary.
4. I accept the responsibility for payment and agree to pay medical, transport and any other related expenses.
5. I confirm that the information contained in this application is true and correct.
6. I agree to inform the leader of any change to these details.

Name of Caregiver _____

Signature of Caregiver _____

Date _____

If other than a parent or guardian, please indicate relationship to child: _____