



AFL CAPE YORK "KICKSTART PROGRAM" PERMISSION AND INFORMATION FORM YEAR _____



67106529257
PO Box 143
Manunda 4870

AFL Cape York requires the information requested below to assist us, in case of any medical or other problems with the child provided for in this form. All information is held in confidence, and is only used during the calendar year to which it relates. This form is retained by AFL Cape York until it is determined that it is no longer required, whereupon it will be destroyed without further notice. If parents/guardians require copies of the form please contact AFL Cape York to arrange for this.

We ask parents/guardians completing this form to complete the information fully and return the form as soon as possible.

CHILD'S DETAILS

SURNAME _____ GIVENNAME/S _____

D.O.B. _____ MEDICARE NO: _____

MALE FEMALE SCHOOL _____

TRADITIONAL CLAN/LANGUAGE GROUPS _____

IF BOARDING SCHOOL – AFTER HOURS NUMBER OF ACCOMMODATION _____

WHERE IS THE CHILD TO BE RETURNED TO AT THE END OF THE EVENT/ACTIVITY? [SPECIFY ADDRESS] _____

MEDICAL INFORMATION

FAMILY DOCTOR _____ CONTACT NO _____

PRIVATE MEDICAL/HOSPITAL FUND NAME _____

MEMBER NO: _____

Is your child presently taking tablets and/or medicine? YES NO
Will your child have the tablets and/or medicine with him/her? YES NO

If yes, please state name of medication, dosage etc. _____

NOTE - ALL MEDICINES MUST BE HANDED TO THE ORGANISER IN CHARGE WHEN ARRIVING AT THE AFL CAPE YORK EVENT OR ACTIVITY, WITH YOUR CHILD'S NAME, THE DOSAGE TO BE TAKEN, WHEN IT SHOULD BE TAKEN AND WHETHER IT REQUIRES REFRIGERATION. PLEASE DO NOT ALLOW YOUR CHILD TO BE IN POSSESSION OF ANY MEDICINE WHILE AT THE EVENT OR ACTIVITY. AFL CAPE YORK RESERVES THE RIGHT TO HAVE THE MEDICATION ADMINISTERED BY A MEDICAL PRACTITIONER OR FOR YOUR CHILD TO BE RETURNED HOME AT YOUR EXPENSE IF THE ORGANISER IN CHARGE FORMS THE VIEW THAT IT WOULD BE PRUDENT TO DO SO ON MEDICAL OR OTHER GROUNDS. AFL CAPE YORK AND ITS STAFF SHALL NOT BE LIABLE FOR ANY ADVERSE CONSEQUENCES ARISING FROM THE ADMINISTRATION OR NON-ADMINISTRATION OF MEDICATION OR THE STORAGE OF THE SAME.

PLEASE TICK IF YOUR CHILD SUFFERS ANY OF THE FOLLOWING:

Bed Wetting <input type="checkbox"/>	Fits of any type <input type="checkbox"/>	Heart condition <input type="checkbox"/>	Blackouts <input type="checkbox"/>
Sleepwalking <input type="checkbox"/>	Asthma <input type="checkbox"/>	Migraine <input type="checkbox"/>	Travel Sickness <input type="checkbox"/>
Behavioral issues <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>	Allergies <input type="checkbox"/>	Dizzy Spells <input type="checkbox"/>
Ear infection <input type="checkbox"/>	ADD <input type="checkbox"/>	ADH <input type="checkbox"/>	

If so medication/care required _____

Has the child been immunized against Tetanus? YES NO Date _____

Has the child been immunized against Hepatitis B? YES NO Date _____

SWIMMING COMPETENCY

Do you give your child permission to take part in any supervised swimming activities undertaken by AFL Cape York? YES NO

AUTHORITY

[NOTE- IF YOU DO NOT MAKE A SELECTION IN ANY OF THE FOLLOWING YOU WILL BE DEEMED TO BE GIVING PERMISSION FOR THE THING CONCERNED]

- I give AFL Cape York permission to transport my child to or at the event/activity by bus, 4WD vehicle or other means considered appropriate and allow the use of vision or sound of any child for AFL Cape York promotion as they see fit.
- I understand that I will not be paid by AFL Cape York for giving this permission.
- I hereby authorize the medical practitioner listed above as the Family Doctor to provide to hospital authorities or other qualified medical practitioner(s) additional information concerning any of the medical conditions listed above should the need arise.
- I hereby authorize the supervising officials to obtain any medical or associated assistance which they deem to be necessary should any medical condition or injury occur.
- I agree to pay any ambulance, medical, dental and/or pharmaceutical expenses incurred on behalf of the above child which are not covered by my personal/family subscription, medical benefits fund (or travel insurance in the case of overseas travel).
- I further authorize qualified practitioners to perform surgery, administer anaesthetic and/or administer blood transfusions if such an eventuality should arise.

I authorize the organizer in charge of the event/activity, where it is impracticable to communicate with me, to the child receiving such medical or surgical treatment as may be deemed necessary. The following contact details are provided in the event that you cannot contact me for any reason.

EMERGENCY CONTACT DETAILS

1st CONTACT	2nd CONTACT
Name:	Name:
Address:	Address:
Relationship to child:	Relationship to child:
Phone No. (Work)	Phone No. (Work)
Phone No. (Home)	Phone No. (Home)
Mobile Phone No.	Mobile Phone No.
Fax:	Fax:

I acknowledge that AFL Cape York activities include participation in contact sports such as Australian [AFL] football and that there is some risk that my child may be injured in play or training.

PLEASE SIGN THIS STATEMENT AND COMPLETE THE DETAILS BELOW

SIGNATURE _____ (Parent/Guardian) DATE _____

YOUR NAME: SURNAME _____ GIVEN NAME/S _____

PHONE CONTACTS: (WORK) _____ (HOME) _____

(MOBILE) _____ EMAIL _____