PRIVATE & CONFIDENTIAL

CHELSEA YACHT CLUB
Longbeach Sail Training Centre

PERSONAL INFORMATION RECORD

Please fill in the details with dark coloured ink

NAME:
Surname**:**_____ Given/ Preferred Name**:**_____

HOME ADDRESS:_____

Suburb: _____Postcode: _____Telephone No:_____

PERSONAL:
Date of Birth: _____Age at Activity: _____Gender: *Male Female*

Chelsea Yacht Club Membership No: _____

Medicare No: _____ Ambulance Ins Number:_____

Private Health Insurance:_____ Priv Health Ins Number:_____

Ancillary Benefits Cover: Yes / No Health Care Card Number: _____

EMERGENCY USE: Details of the Parents/Guardians where they can be contacted during the activity.

NAME: _____Relationship: _____
ADDRESS:_____

Tel number(s) _____ (h) _____(m)

NAME: _____Relationship: _____
ADDRESS:_____

Tel number(s) _____ (h) _____(m)

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HEALTH STATEMENT

If the participant suffers from any chronic or recurrent ailment, allergy or physical incapacity, it should be disclosed so that we are aware of the fact.

A Does the participant suffer from any physical or other disabilities?	Yes / No	If yes, please specify:
B Does the participant suffer From:		Explanation/Medication and treatment required in emergency:
Diabetes?.....Type 1 / Type 2	Yes / No	
Epilepsy?.....Severe / Mild	Yes / No	
Dizzy Spells or Blackouts?	Yes / No	
Travel Sickness	Yes / No	
Migraine Headache?	Yes / No	
Asthma? ..... Severe / Mild	Yes / No	
C Does the participant have any known: **Allergies**? i.e. Penicillin, bee sting, bites, egg, hay fever, other **food**, **drug** or other **environment** related allergy.	Yes / No	If yes, please specify
D Does the participant have any Medications on this activity? i.e. Injection/tablet/capsule Penicillin, insulin, Ventolin, other drugs	Yes / No	Name of Drug: Dosage: Reason or Cause: How Often Administered: Administered by Whom:
E Is there **any further information** you may consider necessary, about which we have not asked above and of which we should be aware (including **special dietary requirements**?) Yes / No If yes, please specify:		
F **Analgesics:** In the event of your child requiring the administration of an analgesic (e.g. Panadol), do you **HEREBY CONSENT** to your child being given the recommended child dosage of Paracetamol or Panadol? Yes / No **If YES, please sign here: _____**		
G **Details of last Anti-Tetanus injections:** Year of Original Injection: _____Year of last booster injection _____		

I hereby **Authorise** the Leader in Charge of the above activity, in circumstances where it is not possible or it is impracticable to communicate with me, to seek for my child, such Surgical, Medical or Dental treatment as a qualified Surgeon, Medical or Dental Practitioner may consider to be necessary (including the transfusion of blood) and I hereby **Consent** to such treatment

Date: _____Signed: (Parent/Guardian) : _____

_____

Print name

Form to be filled out by participant if over 18 years old, or by Parent/Guardian, taken to the event or handed to the Leader in Charge before participant may take part in the activity