Participant Consent Form

St Vincent de Paul Society QUEENSLAND *good works*

Program/Event:	
Location:	
Date:	

Participant Details *Please Print / Tick boxes where applicable*

Full Name			
Address			
Email			
Phone	H:	W:	M:
Gender	☐ **Male** ☐ **Female**	Date of Birth: / /	

Emergency Contact

Full Name			
Relationship			(eg. spouse, parent, friend, etc)
Contact Numbers	H:	W:	M:

Important Information for Participants

Participants with medical conditions can participate fully in St Vincent de Paul Society Queensland ("Society") programs/events when they are able to reliably and independently manage their condition. It is important that the Society also has a good understanding of the participant's condition in order to be able to assist the participant to assess the risk associated with the different environments in which they will find themselves and also to be able to offer the best possible assistance should the participant suffer from a medical emergency. For this reason, we require that all participants who have serious medical conditions that could be aggravated by participating in the program/event (e.g. serious allergies, asthma, heart conditions) fully complete this form.

Participant's Medical History - It is your responsibility to advise us of any changes to your health or medical condition.

Your Doctor		Phone	07
Doctor's Address			

If insufficient space to provide details of all consulted doctors, medical specialists or allied health professionals, attach an additional page. Additional page attached? ☐ **Yes** ☐ **No**

Medicare Number		Expiry Date	/ /20
Health Fund		Membership No.	

Do you suffer from…? If YES, provide full details of your condition, any triggers, medications and recommended care. It is your responsibility to ensure you have sufficient supply with you, for the duration of the program/event, of any medication you are presently taking.

Allergies (medication, food, plant, insect, etc)	☐ **Yes** ☐ **No**	Details:
Asthma	☐ **Yes** ☐ **No**	Details:
Diabetes	☐ **Yes** ☐ **No**	Details:
Epilepsy	☐ **Yes** ☐ **No**	Details:

Participant's Medical History Continued….

Heart Problems	☐ **Yes** ☐ **No**	Details:
Recent serious illness, injury or operation	☐ **Yes** ☐ **No**	Details:
Sleep Walking	☐ **Yes** ☐ **No**	Details:
Migraines	☐ **Yes** ☐ **No**	Details:
Disabilities	☐ **Yes** ☐ **No**	Details:

Provide details of any other medical issues, health conditions, or other relevant information:

Declaration - ☑ Please tick to acknowledge your agreement and consent.

I, *(print full name)* …… request and agree to participate in the program(s)/event(s) stated on this Form ("event") and:

☐ acknowledge I have been provided with full information about the event to enable me to make a fully informed decision to participate. I agree that my participation includes travelling to and from the event as pre-arranged by the Society.

☐ confirm I have disclosed and addressed all areas of concern relating to my participation including any behavioural problems and special medical/dietary requirements. I confirm I will have sufficient supply of any medication I require with me for the duration of the event and will self-administer as required only in accordance with prescribed dosages. I undertake to notify the Society of any health, behavioural or other changes that could potentially alter my participation in the event.

☐ consent to undergo any medical assistance, treatment or intervention required in the case of an emergency, e.g. anaesthetic, blood transfusion, surgery.

☐ consent to the Society using still and/or live footage of me in any forms of advertising and promotion of the Society for an unlimited time and without any further restriction whatsoever. I acknowledge that I do not own the copyright in the sound or vision, and I waive any right to inspect or approve the finished production.

☐ acknowledge that the Society is committed to my safety and wellbeing and that the information contained in this Form will be kept confidential and only used in the case of an emergency.

☐ declare that the information I have provided on this form is true and correct to the best of my knowledge.

SIGNED: ……

DATED: / / 20

Office use Only

Received by: _____ Date / /

Signature: _____

A copy is to be retained at the Diocesan Office for your records and a copy forwarded to the YOUTH DEPARTMENT at State Administration, PO Box 3351, South Brisbane, Q 4101 or Fax: 07 3010 1098