CONFIDENTIAL MEDICAL INFORMATION & DIETARY REQUIREMENTS

Please fill out the following medical report to assist us in ensuring that we are aware of all relevant medical information should it be needed, and to enable us to provide a safe environment for all. All information is confidential.

Name:.. Date of Birth:..............................

Parent/Guardian's Full Name (if applicable) ....

Address:..

Town:... Postcode:..................................

Contact Phone Numbers: (Home) .... (Business)..................................

(Mobile) ....

Emergency Contact Person:

Name:... Relationship:.............................

Address:...

Town:... Postcode:................................

Contact Phone Numbers: (Home) .... (Business).................................

(Mobile) ....

Family Doctor:................................. Clinic Address:..

Clinic Phone:.................................. Medicare Number (optional)..

Do you have Ambulance Cover? Yes / No

Do you suffer from any of the following medical conditions? (please tick where appropriate)

__ Bed Wetting	__ Epilepsy/Seizures	__ Heart Condition
__ Dizzy Spells	__ Sleepwalking	__ Asthma
__ Blackouts	__ Migraines	__ Travel Sickness

__ Other, please specify: ....

What special care (if any) is recommended?

....

....

....

Do you have any known allergies to: (please tick as appropriate)

___ Penicillin ___ Foods ___ Drugs ___ Other

If yes, please specify:...

MEDICAL ALERT

O Severe Asthma

O Anaphylaxis

O Other (Please state)

....

....

Please attach an appropriate Action Plan to this Form

It is the Parent/Guardian's responsibility to ensure PAHQ is provided with all relevant medications and information at all times.

Dietary Requirements

Do you have any special dietary requirements/considerations?
Yes / No (please answer this question seriously!!)

If yes, please specify: (include food allergies, vegetarianism etc)

....

Tetanus

What was the approximate date of your last tetanus booster injection? ....

NB: if it's been over 10 years since your last booster, you are advised to obtain this from your local doctor.

PERFORMING ARTS HEADQUARTERS
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Email: info@pahq.com.au
www.pahq.com.au

MEDICAL CONSENT FORM

Student Name: .... (Print Name)

Under 18 Years of Age

I, ... (Parent/Guardian to Print Name)

hereby authorise **Performing Arts Headquarters,** or an authorised representative, to consent to any necessary medical treatment should an emergency situation arise for my child, (above), during any PAHQ:

- lessons
- rehearsals
- performances
- functions

Signed:.. Date:.................................
(Parent/Guardian Signature)

Over 18 Years of Age

I, ... (Print Name)

hereby authorise **Performing Arts Headquarters,** or an authorised representative, to consent to any necessary medical treatment should an emergency situation arise for myself, (above), during any PAHQ:

- lessons
- rehearsals
- performances
- functions

Signed:.. Date:.................................