



OUTDOOR RE-CREATION
PO Box 2269
Kent Town SA 5071
Ph: 08 8365 2022
Fax: 08 8165 2011
info@earthadventure.com.au
www.earthadventure.com.au

MEDICAL HISTORY

All information provided remains confidential and is required in case of emergency. The information you provide is relevant to those within the medical profession to take immediate action (if necessary) in the most effective and appropriate manner deemed necessary. This will also assist Earth Adventure in providing first aid treatment. All personal information will be filed in accordance with the Privacy Act, 1988.

First Name: _____ Middle: _____ Surname: _____

Birthdate: / / Gender: M / F Contact (if diff. from below): (Hm) _____ (Mob) _____

Address: _____ Postcode: _____

E-mail: _____

Person to contact in an emergency: _____ Relation: _____

Contact Numbers: (Hm) _____ (Wk) _____ (Mob) _____

Medicare Number: _____

Do you have private health cover? _____ What agency: _____

Do you have Ambulance Cover? Y / N

Your family doctors name: _____ Contact number: _____

Do you have, or have you had any of the following... (Please tick with Y or N)

- | | |
|--|--|
| <input type="checkbox"/> Fainting spells or dizziness | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Heart Disease or heart attack or angina | <input type="checkbox"/> Chronic or frequent cough |
| <input type="checkbox"/> Stomach trouble or ulcers | <input type="checkbox"/> Anemia or Haemophilia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Concussion or head injury | <input type="checkbox"/> Arthritis or rheumatism |
| <input type="checkbox"/> Breathing disorder | <input type="checkbox"/> Dislocation/s |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bee / wasp sting reaction |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> A.D.D. |
| <input type="checkbox"/> Epilepsy (Please clarify) | <input type="checkbox"/> Ear disorder |

When was the last episode? _____ Other: _____

If so, when did this occur, what treatment were/are you given and what medication do you require?

If you are hypersensitive, allergic, or have had adverse reactions to medication, food, Tetanus antitoxin or serum, please indicate the agent, the type of reaction and the treatment or medication given.

Have you been exposed to any communicable disease with in the last six months? If so what medication is required, or any special precautions to be taken? YES / NO

Have you ever been advised to have surgery or medical treatment that has not been carried out? YES / NO
If yes, please give details.

Do you have a restricted diet? If yes, please give details. YES / NO

Are you currently taking any medication? If so what medication is required and please list procedure for administration? YES / NO

This information is important and must be completed fully. If not Earth Adventure will not be held responsible.

I _____ deem this information to be correct. Date / /
Parents/guardians signature is required if the person is under 18 years of age.