Deviot Sailing Club Inc.

Parental Consent Form

To be filled in and signed by parent/guardian of Sail Training participant. This page not required for adults.

I hereby give consent form my child (please name child)______________________
to participate in the Sail Training Program conducted by Deviot Sailing Club Inc.

In the event of accident or illness, when it is impracticable or impossible to communicate with me, or my emergency contact, I authorise the adult in charge to consent to my child receiving such medical or surgical treatment as may be deemed necessary. I give permission for my child to receive such treatment as indicated below (please tick appropriate boxes):

- ❑ At the nearest Public Hospital or Government Health Centre
- ❑ At my private doctor or clinic. Dr/Clinic _____________________________
  Address: ____________________________ Phone: ____________________
- ❑ I give permission for my child to be transported there by private car, taxi or ambulance. I agree to pay any charges arising from this transport.
- ❑ I consent to Panadol to be administered by authorised personnel, if deemed necessary.

I agree to notify any changes necessary to the Health Information Sheet for my child subsequent to filling out this form. If such changes are not forwarded, I understand that I may not be able to hold Deviot Sailing Club Inc. liable for any situation that may arise due to lack of information.

I am aware that Sail Training will include water activities such as sailing, swimming, and being a passenger on motorboats.

Signature of Parent or Guardian: ____

Full Name of Parent or Guardian: _______________________________________

Date: ____________________________

Adults' Authority (for adult trainees)

In the event of accident or illness when it is impracticable or impossible to communicate with my emergency contact, or me, I authorise the officer in charge to consent to me receiving such medical or surgical treatment as may be deemed necessary.

Signed: ____

Full Name: _______________________________________

Health Information Sheet - Confidential

Surname____________________
First Name: _________________
Address: ____________________
____
Postcode: _________
Email: ______________________
Medicare No: ______-_______-_______

Home Phone: ________________________
Mobile Phone: _______________________
Emergency Contact name:
____
Emergency contact Phone: _____________
Date of birth: ________________________

General Information

- ❑ Water safe/ Can swim______metres
- ❑ Ear problems
- ❑ Eye problems
- ❑ Diabetes
- ❑ Bee/Insect stings need urgent attention
- ❑ Immunised against tetanus (year): _______
- ❑ Headaches/ Migraines
- ❑ Epilepsy/Fits
- ❑ Heart Condition
- ❑ Hay fever/Allergies
- ❑ Asthmatic – mild/moderate/severe (please circle).

If asthmatic, which medication taken___________________

- ❑ Physical impairment (please specify)_______________________________________
- ❑ Other ailment (please specify)____

Known Allergies

	Mild	Severe	Extreme
Penicillin	☐	☐	☐

Specify Penicillin allergies__________________

	Mild	Severe	Extreme
Food	☐	☐	☐
Bites/Stings	☐	☐	☐

Other known allergies (specify)____

Current Medications

Please specify name of drug	Dosage and frequency	Timing
____________________	__________________	__________
____________________	__________________	__________
____________________	__________________	__________

Headaches/Migraines – What if any pain relief is taken?________________________

Special Needs

Please specify any special needs:____
____

Privacy statement: The information on this form will only be used by the Club for the purposes of providing the sailing activities and in the event of an emergency.