Rochedale Scout Group
Youth Member Medical Statement

If there is insufficient room to provide information, please attach a separate sheet of paper and tick here ☐

Family Name: _____ Given Names: _____

Address: _____

Telephone No: _____ Date of Birth: _____

Religion/Denomination: _____

Medicare No: _____ Are you a member of a private health fund? Yes/No

Fund Name: Membership No: _____

Family Doctor: _____ Telephone No: _____

Health Care/Pension/Veteran Affairs Card No: _____ Card Type: _____

Immunisation: It is recommended that your child be fully immunized as per National Health and Medical Research Council Schedule.

Please provide the date of last Tetanus immunization: _____

Medical Alert necklace/bracelet worn? Yes/No → Necklace/Bracelet→ If yes please provide details

Medial Alert Details: _____

_____

_____

Is regular medication taken? Yes/No → If yes please provide details below

Drug/Medication	Dosage	Method of Administration (timing etc)

Any allergies? Yes/No → If yes please provide details below

Allergy Type	Typical Reaction	Treatment

Medical Aids Yes/No → If yes please provide details below
(Walking stick, wheelchair etc)

_____

_____

Continued over....

Medical Conditions

Please indicate below by ticking the appropriate box any known condition of your child so that the necessary provisions can be made for their welfare. Please also provide any additional information for items ticked.

☐	Angina	☐	Diabetes	☐	Nose Bleeds
☐	Asthma	☐	Epilepsy	☐	Skin Conditions
☐	Blackouts	☐	Hearing Disorders	☐	Sleep Walking
☐	Bleeding Disorders	☐	Heart Condition	☐	Ulcers
☐	Blood Pressure	☐	Hives	☐	Visual Impairment
☐	Bronchitis	☐	Migraines	☐	Other (Inc physical disabilities)

Details of medical condition and support required:

_____

_____

_____

_____

In the event of headache or minor pain, do you give permission for pain relieving medication to be administered by a first aid qualified leader?

No/Yes → If yes please indicate the type of medication permitted:

☐ Paracetamol (Panadol) ☐ Children's Panadol ☐ Aspirin ☐ Ibuprofen (e.g. Nurofen)

In the event of an emergency or accident and we are unable to contact you, please provide details of a relative or friend who may be contacted:

Name: _____ Relationship (if any): _____

Best Contact No: _____

Medical Authority

I authorize any officer, member or servant of the Scout Association of Australia, Queensland Branch Inc, in the event of any accident or illness, to obtain such urgent medical assistance or treatment for the abovementioned member, including the administration of any anesthetic or blood transfusion as he or she may consider expedient and for this purpose engage any first aiders, ambulance officers, doctors, dentists, nursing assistance or hospital accommodation and in the event I agree to pay the said Association in demand all such doctors', dentists', nurses' ambulance and hospital fees (other than fees and expenses recoverable by the said Association under any policy of insurance)

I also authorize any officer or Leader of the Association to administer such pain relief medication as may have been indicated above in the event of minor pain or headache.

Signature: _____ Date: _____
(parent or guardian to sign if member is under 18)

Parent or Guardians Name: _____

Please ensure that this information is kept up to date by advising Leaders in writing of any changes to the information provided.