



Program Induction Form

Over 18 Health & Indemnity Form

Information from this form is confidential and allows us to adequately prepare for your involvement in the program. Thanks for your time!

Date of Induction:..... **Date/s re: amended changes:**.....

Name.....**Address**.....

.....**Phone Number/Mobile**

Age:..... **Date of Birth:**.....**Country of Birth:**

Your Nationality (e.g. Aboriginal/Australian/Vietnamese).....

Emergency contact: Name:

Phone Number..... **Relationship to you:**

Your Doctor.....

Do you have any specific dietary requirements? Please give details......

Are you a: Student Employed Unemployed

Are you receiving a Centrelink benefit? Yes No **If Yes what type:**.....

Are you involved in JPET Yes No **Would you like to be involved in JPET** Yes No

How did you hear about us?

What Adventure activities have you participated in before? (tick relevant boxes)

- | | | | |
|--------------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> caving | <input type="checkbox"/> canoeing | <input type="checkbox"/> skiing | <input type="checkbox"/> cycling |
| <input type="checkbox"/> bushwalking | <input type="checkbox"/> orienteering | <input type="checkbox"/> white water rafting | <input type="checkbox"/> surfing |
| <input type="checkbox"/> snorkeling | <input type="checkbox"/> rock climbing | <input type="checkbox"/> horse riding | <input type="checkbox"/> camping |

What interested you in coming along?

What do you hope to gain from this experience? (tick relevant boxes)

What do you hope to gain from this experience? (tick relevant boxes)

- | | | |
|---|---|---|
| <input type="checkbox"/> have a break | <input type="checkbox"/> feel better about myself | <input type="checkbox"/> experience camping |
| <input type="checkbox"/> feel better about life | <input type="checkbox"/> travel somewhere new | <input type="checkbox"/> learn new skills |
| <input type="checkbox"/> have a holiday | <input type="checkbox"/> take on a challenge | <input type="checkbox"/> relax |
| <input type="checkbox"/> meet new people | <input type="checkbox"/> "get away" from the city | <input type="checkbox"/> not sure |

other comments?.....

MEDICAL CONDITIONS

Fill in table below of any known medical condition that may affect your involvement.

Condition	Yes	No	Likelihood of occurrence	What treatment is required?
Allergy - Drugs				
Allergy - Foods				
Allergy - Insects				
Allergy (please complete Allergy Information on page 3)				
Asthma (please complete Asthma Information on page 3)				
Other Respiratory				
Diabetes				
Epilepsy/Seizure				
Heart Condition				
Migraine				
Sleep Walking				
Mental Illness e.g. depression				
Physical Disability e.g. vision, hearing, restricted movement				
Learning Difficulty e.g. reading				
Infectious Diseases e.g. Hep C, HIV				
Other (Please Specify)				

If you ticked YES for any of the above, have you ever been hospitalized for your condition?

Please advise details.....

MEDICATIONS

Is it necessary for you to take regular medication? YES/NO

Will you be taking medication on the program? If so please itemize in the table below.

Name of Medication	Dose	When to be take & how often	Possible Side Effects

Do you give consent for Adventure Services staff to give the following medications? If so please tick the following boxes to indicate that these medications may be given to you.

Paracetamol Ventolin

Have you ever suffered from a stress related illness? **Yes/No** Do you have any past injuries? **Yes/No**

If so, please give detail

Have you undergone surgery in the past 3 years?

If so, please give detail

How far can you swim without assistance? 0 meters 25 meters 50 meters or more

Do you wear glasses or contacts? **Yes** **No** Date of last tetanus injection/...../.....

Are there any other medical conditions we should be aware of?.....

ASTHMA INFORMATION

Please fill this page in if you ticked the asthma/allergy box on page 2. It is very important that we have the following information. Your time in completing this section is greatly appreciated and assists us in taking the appropriate precautions for you.

Regular medication.....

Quantities and daily dosages.....

Additional medication to be taken during an attack.....

The medications listed above must be brought to the camp by the participant.

Asthma History

When did you last visit the doctor about your condition?

Have you ever been hospitalized for your condition?

Please advise details.....

Known trigger factors (please tick appropriate item)

- Dust of any sort, in sufficient quantities
- Sudden change in temperature
- Contact with animals
- Grass and weed pollens, mould
- Atmospheric pollution
- Physical exercise
- Other – details

What are the signs and symptoms of your asthmatic reaction?

Any further information that you may wish to supply us regarding any medical considerations for you would be greatly appreciated.

.....

ALLERGY REACTION INFORMATION

Have you ever suffered an allergic reaction to:

- Insect bites
- food groups or additives
- plant pollens
- detergents or cleaning agents
- or any other triggers

What are the signs and symptoms of your reaction:.....

.....

Have you at any time in the past suffered from:

- A localized reaction (rash, itching, swelling at the site the poison has entered)
- A systemic reaction (rash, itching, swelling away from the site where the poison has entered)
- An anaphylactic reaction (sever breathing problems, swelling of the body, emergency situation)

What medication do you take (if any) for prevention against allergic reaction?.....

What treatment is required if an allergic reaction occurs?.....

The medications listed above must be brought to the camp by the participant.

Allergic Reaction History.

When did you last visit the doctor about your condition?

Have you ever been hospitalized for your condition?

Please advise details.....

DRUG & ALCOHOL USE – *this information is strictly confidential and for program use only – (guardian(s)/parent(s) are not required to be present whilst you complete the drug & alcohol section)*

If you use drugs or alcohol, what is your current main drug of choice? (tick one below)

- Cigarettes Marijuana Heroin Speed Ecstasy Alcohol
- Inhalants Benzo's Cocaine Hallucinogens Other please state

How often do you use this substance? tried once occasionally regularly can't do without

If you indicated drug/alcohol use above, what is the main way you use this drug? (tick one of the following boxes)

- ingest smoke inject sniff inhale other

If you have injected, when was the last time you did so? (tick one of the following boxes)

- current (last 3 months) recent (more than 3 months ago but less than 12 months) have injected (more than 12 months ago)

If you use more than one drug, what other drugs/alcohol do you currently use?

PARTICIPANT CONSENT

I hereby give permission for any photographs taken of me to be used for promotional purposes.

Signature..... Date.....

INDEMNITY

1. I, **(name)**.....agree to participate on the program to be held on **(dates)**

at **(location)**I understand that the camp will include the following activities

.....and I agree to follow the advice and direction of the leaders.

2. I consent to Baptist Care (SA) (which, in this document includes its agents and employees) Adventure Camping Leaders obtaining any medical treatment I may require.

My Medicare number is.....

I agree to inform Adventure Camping staff of all medication to be taken on the program.

I hereby give permission for BC(SA) Adventure Camping staff to issue medications if elected to do so and to administer nominated medications if required.

3. I understand that in addition to inherent risks associated with Adventure Camping programs there are additional risks and dangers that may be encountered which may include: remoteness to normal medical services; moderated physical exertion for which I may not be prepared, weather extremes subject to sudden and unexpected change; evacuation difficulties if I become impaired.

I agree to observe and fully comply with the safety standards and procedures, as described by Adventure Camping staff for each activity.

I consent to Baptist Care (SA) calling an ambulance service if, in its absolute opinion, it is required, and I agree to indemnify and hold forever indemnified Baptist Care (SA) from all costs arising from or associated with its decision to use an ambulance service.

I understand that BC(SA) shall not be liable for physical injury, or personal loss or damage to personal property except where such injury, loss or damage is due to negligence on the part of BC(SA), its agents and servants; AND I will indemnify and hold harmless and will keep indemnified and held harmless BC(SA) and its agents and servants from all claims, costs, damages, loss, expenses, actions or proceedings arising out of, connected with or in any way related to my participation on the program.

Signed.....(Participant)

This (date).....day of (month)20.....

Customer Information Form

From the 21st of December 2001, the Privacy Act requires us to obtain your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

BC(SA) Adventure Camping collects information from you for the primary purpose of providing you with quality service. We require you to provide us with your personal details, and other relevant information in order that we may understand your needs and respond appropriately to them. We may also use the information you provide for the following purposes:

1. Disclosure to others involved in providing our service to you, including youth organisations. This may occur through referral, advocacy or support. Please note that the Authorisation of Release of Information form will in most cases be completed by you before this occurs.
 2. Disclosure to other BC(SA) workers who are directly involved in providing a service or maintaining records of the service that we provide to you. Please note that all BC(SA) workers have signed confidentiality agreements.
 3. Statistical purposes, including compliance with this service's contractual obligations to funding bodies.
 4. Administrative purposes in running our service.
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DECLARATION

I have read the above information and understand the reasons why my information must be collected. I am also aware that this program has a privacy policy on handling customer information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of service given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this program for the purposes set out above, subject to any limitations on access or disclosure that I notify this program of.

CONSENT

Customer Name (print):

Customer Signature:

Date: / /

HEAD OFFICE

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CITY BASE

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