PO Box 1635
Port Adelaide, SA, 5021
westlakes.canoe.org.au

West Lakes Canoe Club

WLCC EVENT PARTICIPATION PERMISSION FORM

Name of Athlete _____ Date of Birth ____/____/____

ATHLETE PHONE NUMBER _____EMAIL _____

Agreement

- I agree to delegate my authority to supervising team manager. Team Manager may take whatever disciplinary action they deem necessary to ensure the safety, well-being and successful conduct of athletes as a group and individually.
- In the event of any serious misbehaviour on the part of my son/daughter, I understand that I will be contacted and will be responsible for any costs associated with my son/daughter's return.
- In the event of an accident or illness, and in an emergency situation where an ambulance is not available within a reasonable period of time, I consent to my son/daughter being transported to a hospital/medical/dental clinic or to an ambulance by a WLCC member/team manager in a private car.
- In the event of an accident or illness involving my son/daughter, and contact with me or the emergency contact being impossible or unsuccessful despite continued attempts, I authorize the team manager to consent to whatever emergency/critical medical or surgical treatment a registered medical practitioner considers urgent and necessary. I will pay all medical and dental expenses incurred on behalf of my son/daughter. Continued attempts to inform the parent or emergency contact will be undertaken in such circumstances until contact is made.
- I have provided all information necessary for the club to plan safe and reasonable health care support for my son/daughter. This includes, if relevant, information about any activity modifications my child may require for medical reasons.
- I consent to my child's doctor or medical specialist being contacted by medical personnel in an emergency.
- The information given is accurate to the best of my knowledge.

Emergency Family Contacts Parent/Carer

Parent/Carer Full Name	Home	Work	Mobile
Address			

Alternative Emergency Contact

Name	Home	Work	Mobile

Parent/Carer Consent

As a parent/carer to	Athletes First and Second Name	
I,	Parent/Carer Name	
give my consent for her to participate in / at		
From		
Flight Details	ARRIVAL TIME: FLIGHT NO:	DEPARTURE TIME: FLIGHT NO:
Signature and Date		____/____/____

Emergency Medical Contact

If your child becomes unwell or is injured, medical attention will be sought if needed. Please provide name, address and telephone number of any medical personnel currently treating your child who may have information that may help emergency services.

Name	Address	Telephone
Other Information		

Special Circumstances

My child has an injury, allergy or medical condition(s) requiring particular treatment in the event of accident, illness or emergency. ☐ YES ☐ NO

Details of Injury, Allergy OR Medical Condition (including Asthma):

_____

_____

Is there a Medical (Asthma/Allergic Reaction) Management Plan in place? ☐ YES ☐ NO
If YES please attach Medical Management Plan.

Does your child require any modifications to this Plan? ☐ YES ☐ NO
If Yes, please detail:

_____

_____

If No, are you aware of any other medical emergency that could arise?

_____

Checklist and Risk Management:
Please provide details of the emergency and how to recognize it (Please provide extra attachments if necessary)

_____

_____

Emergency Treatment: *(Please provide extra attachments if necessary)*

_____

_____

In the event of an accident or illness, staff will call an ambulance if an emergency situation arises. Staff will make every attempt in the event of an accident or illness to contact you or the alternate emergency contact person. Ongoing attempts to contact the parent or alternative emergency contact person will be made until successful contact occurs. In the event that contact is impossible or delayed, are there any special instructions to be given to the ambulance staff? If so, please add these below:

_____

_____

MedicAlert number (if applicable)

Medications will need to be self administered if the child is considered by their parent/carer to be capable. Children must be aware of dosage instructions and comply with specified times. If there is concern with self administration the parent/carer must indicate below and make arrangements with team manager/coach.

Child is able to self administer any medications ☐ YES ☐ NO ☐ N/A
Team Manager / Coach is aware of requirements ☐ YES ☐ NO ☐ N/A

Parent/Carer Signature and Date

____/____/____

Dietary Requirements

Please list any dietary requirements .

Asthma Management Plan

Only complete this page if the participant suffers from asthma.

Medications will need to be self administered. Children must be aware of dosage instructions and comply with specified times. If there is concern with self administration the parent/carer must indicate below and make arrangements with team manager/coach.

This information will be kept strictly confidential however will be provided to ambulance/medical personnel in the event of an emergency. This is not an agreement that WLCC will administer medication.

(This level of information is recommended as a minimum by the Asthma Foundation)

Please seek advice from your medical practitioner if necessary.

Name of participant: .....

Regular medication: .....

Quantities and daily dosages:.....

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

Expected best Peak Expiratory flow reading: .....

Peak Expiratory flow reading requiring extra medication: .....

Peak Expiratory flow reading when advisable to seek medical assistance: .....

Known trigger factors (please tick any appropriate item)

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

Details: .....

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Parent/Legal Guardian..... **Date** ...../...../.....

Allergic Reaction Management Form

Only complete this page if the participant suffers from allergic reactions.

Medications will need to be self administered. Children must be aware of dosage instructions and comply with specified times. If there is concern with self administration the parent/carer must indicate below and make arrangements with team manager/coach.

This information will be kept strictly confidential however will be provided to ambulance/medical personnel in the event of an emergency. This is not an agreement that WLCC will administer medication.

Please seek advice from your medical practitioner if necessary.

Name: .....

Allergic to .....
What are the signs and symptoms of the reaction (what should we be looking out for)?

.....

.....

Have you at any time in the past suffered from?

- ❒ **A localised reaction** (any rash, itching, swelling at the site the poison has entered)
- ❒ **A systemic reaction** (any rash, itching swelling away from the site where the poison has entered)
- ❒ **An anaphylactic reaction** (severe breathing problems, swelling of the body, emergency situation)

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

All medication for the sufferer's allergic reaction must be brought on the activity/event/program and given to the supervising officer/ event/program organiser worker in charge.

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

Five vital questions – (please answer by circling)

1. Do you suffer a systemic reaction to your allergy?	❒**No**	❒**Yes**
2. Do you have an anaphylactic reaction to your allergy?	❒**No**	❒**Yes**
3. Is there a family history of anaphylaxis?	❒**No**	❒**Yes**
4. Have you ever been hospitalised due to an allergic reaction?	❒**No**	❒**Yes**
5. Is adrenaline (eg adrenaline injection, epi-pen) administered when you suffer from an allergic reaction?	❒**No**	❒**Yes**

If you have answered 'yes' to **any** one of these 5 vital questions, you must:

*** Consult your doctor about participation in the program.**

*** Have the full agreement of the Coordinator and your Medical Practitioner.**

Parent/Legal Guardian..... **Date** ...../...../.....