



ORIENTEERING NSW Inc, PO Box 3379, NORTH STRATHFIELD NSW 2137  
PHONE: (02) 8736 1252 • EMAIL: [admin@onsw.asn.au](mailto:admin@onsw.asn.au) • WEB: [www.onsw.asn.au](http://www.onsw.asn.au)

## Orienteering NSW Junior Development Squad Squad Member Information Form

### Participants Details:

Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of School: \_\_\_\_\_

Orienteering Club: \_\_\_\_\_

### Parent/Guardian Details:

**Mother** Full Name: \_\_\_\_\_

Phone: (W) \_\_\_\_\_ (H) \_\_\_\_\_  
(Mob) \_\_\_\_\_

Email: \_\_\_\_\_

**Father** Full Name: \_\_\_\_\_

Phone: (W) \_\_\_\_\_ (H) \_\_\_\_\_  
(Mob) \_\_\_\_\_

Email: \_\_\_\_\_

The best number for contact during the training camp:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_





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## Orienteering NSW Junior Development Squad

### Squad Member Medical Information

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Health Care Card Number: \_\_\_\_\_

Private Health Insurance Fund: \_\_\_\_\_

Private Health Insurance Number: \_\_\_\_\_

Pensioner Health Benefits Card: \_\_\_\_\_

Pharmaceutical Benefits Concession Card: \_\_\_\_\_

Do you have ambulance cover? Yes No Provider \_\_\_\_\_

Has the participant had the combined diphtheria tetanus toxoid booster injection?

Yes No Year \_\_\_\_\_

Does the participant suffer from any of the following?

Anaphylaxis

Epilepsy

Skin condition

Disability or chronic condition

Diabetes

Asthma

A current illness eg. Flu

Any allergic condition

Reactions to drugs

Sun screen sensitivities

Other \_\_\_\_\_

If yes to one or more of the above, please give details including details of any specific first aid treatment that the participant may require as a result of their condition:

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Does the participant have any Special Dietary Needs: Yes No

If Yes please provide details: \_\_\_\_\_

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Extra pages attached that detail first aid or dietary needs



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## Orienteering NSW Junior Development Squad Squad Member Medical and Media Consent Form

Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_

Does the participant have any regular medication that they will need to take during the training camp?

Yes                      No

Will they require assistance/supervision to take this medication?    Yes                      No

Please provide details of medication and dosage below

Medication 1:

Name of medication \_\_\_\_\_

Dosage \_\_\_\_\_

Medication 2:

Name of medication \_\_\_\_\_

Dosage \_\_\_\_\_

***Please ensure that all medication is labelled with your child's name, dosage and frequency of administration.***

I give permission for my child to be given paracetamol for temporary pain relief.

I give permission for my child to be given Hydralyte or equivalent as required for treatment of dehydration.

In the case of my child requiring medical treatment I consent to the team manager or the team coach providing, or arranging for the provision of, first aid to my child and I further authorise the team manager or the team coach, where it is impracticable to contact me, to arrange for my child to receive such medical or surgical treatment as may be deemed necessary. I also undertake to pay any costs which may be incurred for the medical treatment, ambulance transport or drugs.

### Media Release

I agree to the use of photographic and video material involving images of my child for promotional and reporting purposes during and following the training camp 2015.

Signed to indicate consent to both medical treatment and media release

\_\_\_\_\_  
Name and relationship to child

