

Medical Information and Consent Form

Medicare number: _____

In an emergency please contact:

Name: _____

Phone: _____ Relationship: _____

Do you suffer from any medical conditions which the AWC Committee need to be aware of? Yes No

If yes, please give further details: _____

If you have ticked yes above please specify your emergency treatment plan: _____

Treating Doctor's name and phone number: _____

We respectfully request that you secure any medication you choose to bring to AWC09. Please see a committee member for any special requirements and ensure that a current treatment plan, including medication and dosage, comes with you if required. This may remain with you, or if preferred you may provide it in a sealed envelope upon arrival for emergency use. This will be returned unopened upon departure. **Any drugs which are not prescribed, or which are not 'over the counter' should not be bought to AWC09.**

Privacy Statement: The information on this form, which includes health information, is collected for the primary purpose of best managing any health or safety emergency that may involve you during AWC09. Other purposes of collection include eliminating or minimising the risk of aggravating any pre-existing injury or illness that you are aware of and disclose. If you choose not to complete all questions on this form, it may not be possible for the committee to provide the best possible response to any emergency involving you or to take all reasonably practicable precautions to eliminate or minimise the risk of aggravating any pre-existing injury or illness. Personal information may also be disclosed to emergency services personnel or medical personnel.

Release Notice

- I hereby declare that the information I have provided to PASA Inc for the purpose of registration and care at AWC09 is current and correct.
- I commit to notifying the organisers of any changes upon arrival at AWC09.
- In case of emergency I authorise those in charge to take any steps they may consider necessary for the safety or well-being of myself, including ambulance travel, medical treatment, hospitalisation, etc. I understand that I am responsible for any treatment costs.
- If needed, I accept responsibility for my own use and dosage of any prescribed or purchased medications. I know of any adverse effect they may cause, or have made a statement on the medical information form otherwise.
- I understand that the venue is a no smoking site.
- I understand that any amount paid will be refunded in full if cancelled before 15th July, one half refunded if cancelled before 15th August, and no refund of any money if cancelled after 15th August.

Can you provide transport to and from the venue for any other participants, or provide a lift from a local bus or train station? Please state the suburb you come from and details of what you can provide. Many thanks if you can!

Signed _____ Date _____

Office Use Only:

Registration No.: _____ Payment Received: _____ Date: _____ Cash Money Order Cheque

Banked: _____ Receipt No.: _____ Issue Date: _____

Medical: _____ T-Shirt: _____ Other: _____
