

# EXODUS

## Outdoor Adventures

### MEDICAL CONSENT FORM

#### PARTICIPANT'S DETAILS

Name: \_\_\_\_\_ Male / Female  
Address: \_\_\_\_\_ State: \_\_\_\_\_ Post Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

#### MEDICAL INFORMATION

Medicare No: \_\_\_\_\_ Other Health Care: *(Specify)*  
\_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
\_\_\_\_\_

Contact Person in Emergency: \_\_\_\_\_ Phone No: \_\_\_\_\_  
\_\_\_\_\_

Do you suffer from any allergies? YES / NO

If YES, Type, Severity and Treatment (Please write information on the back of this form).

a) Drug-related allergies (eg. Penicillin)

b) Environmental allergies (eg. Plants, animals)

Treatment: \_\_\_\_\_  
\_\_\_\_\_

c) Food allergies:

Do you suffer any conditions requiring medication (eg. Epilepsy, Asthma)? YES / NO.

If YES, please supply details of condition, medication, name and contact number of treating doctor, and date of last occurrence.

Have you suffered any recent illnesses or injuries? YES / NO. If YES, give details of illness or injury.

Current treatment: \_\_\_\_\_  
\_\_\_\_\_

Do you suffer any phobias or behavioural disorders? YES / NO

Treatment: \_\_\_\_\_  
\_\_\_\_\_

Have you had a tetanus booster in the last 10 years? YES / NO. Date of last booster \_\_\_\_ / \_\_\_\_ / \_\_\_\_

#### AUTHORITY FOR MEDICAL TREATMENT

Parents or Legal Guardians approval must be given for anyone under 18 years of age.

In an emergency, I authorise the staff of Exodus Outdoor Adventures to give myself / my son / my daughter such medical treatment as is necessary. In doing so, I agree to pay any medical or hospital expenses if this may incur.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

