

**Albert Park Yacht Club** INC.



*Established in 1871*



## WINTERSAIL 2011

### PARENTAL/GUARDIAN CONSENT FORM

Please print clearly

**Sailors Name:** \_\_\_\_\_

**Class:** \_\_\_\_\_

I, \_\_\_\_\_ of \_\_\_\_\_

consent to my son/daughter attending the Wintersail 2011 as per the terms and conditions accepted in the online entry process. I hereby authorise the organisers to permit my son/daughter to be given necessary drugs or anaesthetic and to be operated upon, in the event of a medical emergency, if such treatment is considered necessary, by a duly qualified medical practitioner during the period 15<sup>th</sup> – 17<sup>th</sup> July 2011. This permission is given providing **every effort** is made to contact me personally before any decision is made to administer drugs, anaesthetise or operate.

**The information contained on this form is, to the best of my knowledge, true and correct.**

**Signed:** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
[Parent/Legal Guardian of sailor listed above and residing at the address shown there on]

**PLEASE RETURN COMPLETED FORMS TO**

**WINTERSAIL,**  
Albert Park Yacht Club  
PO Box 3  
ALBERT PARK VIC. 3206

Ph: 0411 741 417

# PRE-PARTICIPATION QUESTIONNAIRE

All information on this sheet is confidential.

Access to this sheet is limited to Director, Sports First Aider, Sports Trainer and Coach



## Personal Details

Surname	<input type="text"/>	Given Names	<input type="text"/>	
Address	Street Address <input type="text"/>		Home Phone	Area Code <input type="text"/> Number <input type="text"/>
	Suburb / Town <input type="text"/>	State <input type="text"/>	Postcode <input type="text"/>	Business Phone
		Area Code <input type="text"/>	Number <input type="text"/>	
Sex	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of Birth	<input type="text"/>
			Mobile Phone	Number <input type="text"/>

## Emergency Contact

Surname	<input type="text"/>		Given Names	<input type="text"/>	
Home Phone	Area Code <input type="text"/>	Number <input type="text"/>		Business Phone	Area Code <input type="text"/> Number <input type="text"/>
Relationship	<input type="text"/>		Mobile Phone	Number <input type="text"/>	

## Health Care Details

Medicare Number	<input type="text"/>	Private Health Insurance	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fund	<input type="text"/>
Private Doctor	Name <input type="text"/>	Telephone	Area Code <input type="text"/>	Number <input type="text"/>		
Can Doctor be contacted at all times?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, AH contact	Area Code <input type="text"/>	Number <input type="text"/>	
Private Dentist	Name <input type="text"/>	Telephone	Area Code <input type="text"/>	Number <input type="text"/>		
Can Dentist be contacted at all times?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, AH contact	Area Code <input type="text"/>	Number <input type="text"/>	

## Other Commitments

Do you participate in other sports Yes  No

Do you attend other Groups (e.g. scouts, Venturers, etc) ? Yes  No

Please list other activities that you have a regular commitment to (e.g. part time work, music, etc)

If yes, please complete table below for each sport

Sport	Number of sessions / week	Approx length of sessions

If yes, please complete table below for each group

Group / activity	Number of sessions / week	Approx length of sessions

If yes, please complete table below for each sport

Activity	Number of sessions / week	Approx length of sessions

# Medical Details

Blood Group

Do you object to transfusions? Yes  No

Have you received medical clearance from your doctor for this season? Yes  No

Do you take any regular medications?

If yes, please list

## Have you had . . .

- Epilepsy Yes  No   
 Hepatitis A Yes  No   
 Hepatitis B Yes  No   
 Diabetes Yes  No   
 Heart Problems Yes  No   
 Heart Murmur Yes  No   
 Hernia Yes  No

## Concussion . . .

Have you ever had concussion? Yes  No

How many times?

Give approx dates

Do you wear protective head gear? Yes  No

If yes, specify

## Vision

Do you wear:

- Glasses Yes  No   
 Hard contact lenses Yes  No   
 Soft contact lenses Yes  No

## Teeth . . .

Do you wear a Mouthguard? Yes  No

If yes, specify type

Do you wear your mouthguard:  
 at training Yes  No   
 at competition Yes  No

## Asthma . . .

Do you suffer from asthma? Yes  No

Do you take medication? Yes  No

If yes, specify

Do you bring your medication to training/competition? Yes  No

## Vaccinations

Have you been vaccinated against:

- Hepatitis A Yes  No   
 Hepatitis B Yes  No   
 Tetanus Yes  No   
 Other Yes  No

If other, please specify

HIV status (optional)

## Allergies . . .

Are you allergic to:

- Tape Yes  No   
 Ice Yes  No   
 Medications Yes  No

Please specify medications

List any other allergies you have:

# Injury Details

Were you injured last season? Yes  No

If yes, please list

Are there any past injuries still affecting your performance (e.g pain, stiffness)? Yes  No

If yes, please list

Do you wear protective equipment? Yes  No

If yes, please list

Do you require specific taping / padding for a previous injury? Yes  No

If yes, please specify

Have you sustained a fracture in the last 3 years? Yes  No

If yes, please list

Have you sustained a dislocation in the last 3 years? Yes  No

If yes, please list

Have you ever had a head, neck or spinal injury? Yes  No

If yes, please give details

To the best of my knowledge, all information contained on this sheet is correct (if under 18 please have a parent or legal guardian sign)

Signature

Date