

staff liaison member

medical summary



Great Alpine Way
Dinner Plain
Victoria 3898
Phone 5159 6580
Fax 5159 6618

Please use BLOCK LETTERS

Staff member name(s) Mr / Mrs/ Ms _____

School name and address _____

Principal _____

Emergency contact name _____ Relationship to staff member _____

Contact person's (work) _____ (home) _____
telephone number (mob) _____

Date of birth / /

Do you hold a current First Aid certificate? Yes / No Please detail _____

Are you a qualified teacher? Yes / No Please indicate subject areas _____

Do you hold your: Bronze medallion Yes / No Drivers licence Yes / No Endorsed licence Yes / No

Please indicate your experience in Outdoor Education or Special Skills _____

Special notes (for example, dietary requirements) _____

Major illnesses or impairments

Please indicate any restrictive physical conditions _____

Allergies _____ Medications _____

Allergies to medications _____

Please indicate type of impairment: Impaired Hearing Impaired Vision Impaired Speech Impaired mobility

Medical insurance details

Doctor's name _____

Clinic address _____

_____ Phone number () _____

Medicare number _____

Do you have Private Health cover? Yes / No If Yes, please indicate organisation and membership no. _____

Do you have Ambulance cover? Yes / No If Yes, please indicate membership no. _____

I authorise The Alpine School to arrange for ambulance transport for me if necessary. _____

Signed _____ / /

This form is to be completed by the liaison teacher and sent to The Alpine School 2 weeks prior to program.