Statement of Participant Medical Health

Dear Doctor, The individual seeing you today is a prospective participant in an outback adventure therapy program. It will be conducted by the Operation Flinders Foundation in the Northern Flinders Ranges. The Program will involve living in the field, eating concentrated rations and strenuous physical activity. Participants must have the physical and psychological capacity to cope. Teams of 10 participants and 4 adults will walk up to 100Km in 8 days over rough and sometimes steep terrain carrying a 15kg backpack and sleep in field conditions. Qualified paramedics will be stationed in the area to provide primary medical care. Please complete this assessment and return it as detailed. Whilst we appreciate that many doctors are happy to assist these young people by not charging full costs, there is no expectation that this should be the case. If you require further information contact Operation Flinders on (08) 8245 2666

School/Agency *

Participant Name *

First Name Last Name

Medicare Number *

Healthcare Card Number

Issuing Doctor's Name *

First Name Last Name

Medical Assessmnet

Date of birth *

Day Month Year

Weight *

Height *

BMI *

Blood Type

Tetanus vaccination in the last 10 years? *

- Yes
- No
- Unsure

Respiratory System *

- Normal
- Abnormal

History of asthma or other breathing difficulties

Musculoskeletal System *

- ○ Normal
- ○ Abnormal

History of feet, back and/or joint disorders

Cardiovascular System *

- ○ Normal
- ○ Abnormal

Brief description of abnormality

Blood pressure and pulse

Nervous System *

- ○ Normal
- ○

History of migraines, epilepsy or locomotor disorders

Metabolic/Hormonal *

- ○ Normal
- ○ Abnormal

History of diabetes/other disorders

Allergies *

- ○ Yes
- ○ No

History of severe hay fever, food allergies or any history of anaphylaxis (Participant will need to carry an Epipen).

Psychological *

- ○ Normal
- ○

History of significant psychological or psychiatric disorders

Developmental disorders *

- ○ Yes
- ○ No

Brief details (ASD, cognitive delay etc)

History of bed wetting or continence issues *

- ○ Yes
- ○ No

Medications

Current medications and dosing

Allergies/ intolerance to medications

Any special medical diets

After consulting with the parent/caregiver please specify which of the following non-prescription medications may be administered to this person during a field exercise. (Only administered if deemed appropriate by the paramedic) *

- ☐ None
- ☐ Paracetamol
- ☐ Ibuprofen
- ☐ Certrazine (or similar)
- ☐ Salbutamol Inhaler
- ☐

Please specify

General Comments

Any other impairments/ disorders that would limit ability to participate?

Hospitalised in the last 12 months? Brief reason? Fully recovered?

Recommendation

Based on my examination of the prospective participant's medical history, and keeping in mind the strenuous nature of the activities to be performed, the participant is *

- ○ Medically fit
- ○ Medically unfit

Legally Qualified Medical Practitioner Name *

Phone Number *

Please enter a valid phone number.

Stamp *

Date *

Day Month Year