



# Edmund Rice Camps NSW

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An Activity of the Edmund Rice Foundation Ltd  
ABN 20 067 072 726

## CONTACT SHEET

NAME: .....

ADDRESS: .....

..... POSTCODE: .....

DATE OF BIRTH: .....

GENDER: (please circle)      Male / Female

PHONE: (Home).....

(Mobile) .....

E-MAIL: .....

### PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name..... Relationship.....

Address .....

Emergency Phone : Home..... Daytime.....

Mobile.....

### QUALIFICATIONS

- |   |          |       |
|---|----------|-------|
| <input type="checkbox"/> Senior First Aid       | Expires: | _____ |
| <input type="checkbox"/> Bronze Medallion       | Expires: | _____ |
| <input type="checkbox"/> Austswim               | Expires: | _____ |
| <input type="checkbox"/> CPR Certificate        | Expires: | _____ |
| <input type="checkbox"/> Abseiling Instructor   | Expires: | _____ |
| <input type="checkbox"/> Orienteering           | Expires: | _____ |
| <input type="checkbox"/> Canoeing Instructor    | Expires: | _____ |
| <input type="checkbox"/> LR bus licence         |          |       |
| <input type="checkbox"/> Manual driving licence |          |       |
| <input type="checkbox"/> Other: .....           |          |       |

Camp You wish to attend: \_\_\_\_\_

**EDMUND RICE CAMPS MEDICAL INFORMATION.**

*This report is required to ensure the health, safety and welfare of all. All information will be held in strict confidence.*

**NAME:** \_\_\_\_\_

1. Doctors Name: .....  
Address: .....  
Ph. Number: .....
2. Medicare number.....
3. Medical fund and member No: .....
4. Date of last tetanus injection.....
5. Have been immunized against Hepatitis B: Yes  No
6. Please tick if you suffer from :
- |              |                          |                          |                          |                 |                          |             |                          |
|--------------|--------------------------|--------------------------|--------------------------|-----------------|--------------------------|-------------|--------------------------|
| Blackouts    | <input type="checkbox"/> | Sleepwalking             | <input type="checkbox"/> | Travel sickness | <input type="checkbox"/> | Diabetes    | <input type="checkbox"/> |
| Dizzy spells | <input type="checkbox"/> | Migraine                 | <input type="checkbox"/> | Fits/seizures   | <input type="checkbox"/> | Head Injury | <input type="checkbox"/> |
| Asthma.      | <input type="checkbox"/> | Heart condition          | <input type="checkbox"/> | Bed wetting     | <input type="checkbox"/> | Heatstroke  | <input type="checkbox"/> |
| Epilepsy     | <input type="checkbox"/> | Operation past 12 months | <input type="checkbox"/> |                 |                          |             |                          |
- Other .....
7. Please tick if you suffer from allergies to:
- |            |                          |       |                          |            |                          |
|------------|--------------------------|-------|--------------------------|------------|--------------------------|
| Penicillin | <input type="checkbox"/> | Foods | <input type="checkbox"/> | Bee Stings | <input type="checkbox"/> |
| Any food.  | <input type="checkbox"/> | Drugs | <input type="checkbox"/> |            |                          |
- Other.....
8. Do you have any personal requirements?.....

I authorise Edmund Rice Supervisors in the event of any accident or illness and where it is not possible or reasonable to obtain my consent at that time, or in the case of a minor, parental / guardian consent, to obtain the necessary medical assistance or treatment. For this purpose I authorize those previously listed to engage any doctors, nursing assistance, hospital facilities or accommodation. I agree to pay all such doctors, nurses, or hospital expenses incurred.

Signature..... Date.....  
Signature Parent/Guardian (if under 18)..... Date.....