ULTIMATE SLEEPOVER - REGISTRATION FORM

LEEUWIN
Ocean Adventure Foundation

Please complete and email to office@sailleeuwin.com

For more information: www.sailleeuwin.com

OFFICE ONLY

Medical ☐ Y
Missing Info ☐ Y ► Provided Y ☐
received: _____
Approved: _____
Emailed: _____ / _____
Entered: _____

1. EVENT DETAILS

Date: 7 February 2022

2. PARTICIPANT DETAILS

Gender: ◯ M ◯ F ◯ Diverse Gender Identity

First Name: _____ Surname: _____

Address: _____ Suburb: _____

State: _____ P/C _____ Phone: _____

Email: _____ Mobile: _____

Age _____ _____ DOB: ____/____/_____

Do you identify as an Indigenous Australian? ◯ Y ◯ N or Torres Strait Islander? ◯ Y ◯ N

3. EMERGENCY (SHORE) CONTACT DETAILS

First Name: _____ Surname: _____

Relationship to participant: ◯ Mother ◯ Father Other: _____

Email: _____ Mobile: _____

4. DIETARY REQUIREMENTS

This section refers to medical allergies, not preferences/likes or dislikes.

I am: ☐ vegetarian ☐ lactose intolerant ☐ gluten free

Please provide any additional details: _____

5. MEDICAL INFORMATION

Please tell us if you have or ever had the following conditions:

Abnormal response to heat/cold	Y ○	N ○	Head injury/concussion	Y ○	N ○
Aggression issues	Y ○	N ○	Heart or circulatory disorder	Y ○	N ○
Allergies - Drugs	Y ○	N ○	Haemophilia or bleeding problem	Y ○	N ○
Allergies - Food	Y ○	N ○	Hepatitis	Y ○	N ○
Allergies - Bites	Y ○	N ○	Hernia	Y ○	N ○
Anaemia	Y ○	N ○	HIV/AIDS	Y ○	N ○
Anaphylaxis ✱	Y ○	N ○	Impaired hearing	Y ○	N ○
Arthritis or rheumatism	Y ○	N ○	Impaired movement	Y ○	N ○
Asthma/breathing difficulties ✱	Y ○	N ○	kidney or bladder problems	Y ○	N ○
Autism	Y ○	N ○	Learning difficulties	Y ○	N ○
Anxiety or depression	Y ○	N ○	Loss of balance/coordination	Y ○	N ○
Behavioral problems/ADD/ADHD	Y ○	N ○	Memory/attention problems	Y ○	N ○
Blood disorders/leukaemia	Y ○	N ○	Mental disability	Y ○	N ○
Bone or joint injury	Y ○	N ○	Mental illness	Y ○	N ○
Cerebral Palsy	Y ○	N ○	Osteomylitis	Y ○	N ○
Claustrophobia	Y ○	N ○	Physical disability	Y ○	N ○
Dependence on any substances	Y ○	N ○	Pregnancy	Y ○	N ○
Diabetes (Type 1)	Y ○	N ○	Speech difficulty	Y ○	N ○
Diabetes (Type 2)	Y ○	N ○	Spinal injury/disorder	Y ○	N ○
Eating Disorder	Y ○	N ○	Thyroid disorders	Y ○	N ○
Epilepsy/fits/convulsions	Y ○	N ○	Tuberculosis	Y ○	N ○
Eye disease/vision impairment	Y ○	N ○	Vertigo	Y ○	N ○
Fainting/blackouts	Y ○	N ○	Other: _____		

✱ For anaphylaxis and asthma conditions, an Action Plan is required.

ABOUT YOUR MEDICAL CONDITION(S):

CONDITION	DETAILS OF THE CONDITION AND ANY OTHER RELEVANT MANAGEMENT ISSUES

MEDICATION	DOSAGE INFORMATION

MEDICAL PRACTITIONER CONTACT DETAILS:

Doctors Name:_____ Phone Number: _____

Address: _____