

# Health and Wellbeing Form



This form must be completed by an athlete's parent or guardian and returned to the Team Manager.  
If you have any questions or require assistance completing the form please contact your Team Manager.

## Athlete Details

First Name:

Last Name:

Postal Address:

Phone:

Mobile:

DOB:

Male

Female

## Parent/Guardian Details (who completed this form)

First Name:

Last Name:

Postal Address:

Phone:

Mobile:

## Parent/Guardian Permission Agreement

By signing below, I understand that:

- This information is necessary so that appropriate staff, volunteer supporters and equipment can be arranged and a safe and enjoyable event can be organised for each athlete.
- Information from the completed health and wellbeing form is accessible by staff and volunteer supporters who will be linked with each athlete.
- Some information may be provided to other staff or volunteers supporters who attend the event.
- I must advise the Team Manager if there is any information, which is particularly confidential, which should not be given to volunteer supporters or other people (see last bullet point below).
- All staff and volunteer supporters attending the event have signed a confidentiality agreement.
- The information provided on this form is current and accurate and I take responsibility for letting the Team Manager know of any changes to the information.
- I authorise any medical care urgently required by my child/young person (athlete) during the event.
- There will be no charge for any onsite nursing/first aid support required but that I will cover any additional costs that are incurred as a result of this.
- Staff and volunteer supporters involved in the event will exercise due care but I appreciate that accidents can happen.
- The Team Manager, Event Organisers and CCS Disability Action will not be liable for any injury, damage or loss that my child/young person may sustain to person or property.
- The Event Organisers may use any photographs or videos taken at the event of the athletes for promotional purposes.
- The Event Organisers may pass information from this form to a local Sports Opportunity Officer so that they can work with athletes to access local sports and recreation possibilities.

Athlete Signature (if 16+)

Parent/Guardian Signature:

Parent/Guardian Name:

## Emergency Contact Details

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Mobile: \_\_\_\_\_

Address: \_\_\_\_\_

## HEALTH INFORMATION

### Disability

Please describe the athlete's disability(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Mobility

Does the athlete use any mobility related equipment?  Yes  No

If yes, please list any aids/equipment that the athlete uses (eg: crutches, walker, braces, bike, stroller):

\_\_\_\_\_

\_\_\_\_\_

Does the athlete require any assistance?  Yes  No

If the athlete uses a wheelchair what type is it?  Manual  Electric  Scooter

If manual, can the athlete operate it?  Yes  No

Can the athlete transfer to a bus /car seat?  Yes  With Assistance  No (must be in own chair)

Please give details:

\_\_\_\_\_

Can the athlete transfer to a theatre seat?  Yes  With Assistance  No (must be in own chair)

Please give details:

\_\_\_\_\_

### Communication

How does the athlete communicate with other people?

Verbally  Sign Language  Gestures  Communication book

Other

Is English the athlete's second language?  Yes  No

If yes, what helps the athlete make his/her needs known (eg: gestures, communication book, interpreter)

\_\_\_\_\_

\_\_\_\_\_

## Sensory

**Vision** – Does the athlete experience vision difficulties?

Yes

No

If yes, please specify issues, aids used and what difference they make:

**Hearing** – Does the athlete experience hearing difficulties?

Yes

No

If yes, please specify issues, aids used and what difference they make:

## Behaviour

Does the athlete require any support for any behaviours he/she has?

Yes

No

If yes, please describe in terms of activity level, attention span, impulsiveness etc:

Please give details eg, triggers and suggestions for support:

## Emotional / Mental Wellbeing

Does the athlete have or had any times of emotional or mental difficulties?

Yes

No

If yes, please give details (eg: triggers, suggestions for support):

## Daily Routines

Does the athlete need assistance getting out of or into bed?

No

Partial Help

Total Help

If help required, please give details:

Does the athlete need assistance with dressing?

No

Partial Help

Total Help

If help required, please give details:

Does the athlete need assistance with eating /drinking?

No

Partial Help

Total Help

If help required, please give details:

Does the athlete need assistance with showering?  No  Partial Help  Total Help

If help required, please give details:

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Does the athlete need assistance brushing teeth/hair etc?  No  Partial Help  Total Help

If help required, please give details:

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## Nightly Assistance

Does the athlete require assistance or direct supervision during the night?  Yes  No

If yes, please give details (eg: turning, using the toilet):

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## Skin Care

Does the athlete's skin require particular attention?  Yes  No

If yes, please give details:

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## Swimming

Does the athlete feel confident in the water?  Yes  No

Is he/she an independent swimmer?  Yes  No

If no, what assistance does he/she require?

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## Food

Does the athlete have any food allergies or a special diet?  Yes  No

If yes, please give details:

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## Medical

Does the athlete have asthma?  Yes  No

If yes, please give details (eg: triggers, management):

Does the athlete have diabetes?  Yes  No

If yes, please give details (eg: type, management):

Does the athlete have epilepsy?  Yes  No

If yes, please give details (eg: type, frequency, usual times):

How long does a seizure usually last?

Please give details (eg: triggers, management, stesolid, when to call the ambulance):

## Bowel and Bladder Management

Does the athlete need to be prompted to use the toilet?  Yes  No

Does the athlete have bladder control? (Day time)  Yes  No

(Night time)  Yes  No

Does the athlete have bowel control?  Yes  No

Does the athlete need a daily evacuation?  Yes  No

Does the athlete use suppositories?  Yes  No

Does the athlete require an ACE procedure  Yes  No

Frequency:

Does the athlete use any other aids or appliances?  Yes  No

Details :

How much assistance, if any, from support staff does the athlete require?

Is the athlete on a catheterisation program?  Yes  No

If yes please give details (frequency etc):

How much, if any, assistance from support staff does the athlete require?

## Medication

Is the athlete currently taking any medication?  Yes  No

If yes, please complete and sign the medication details sheet at the end of this form.

Does the athlete have any drug allergies?  Yes  No

If yes, please give details (eg: allergic to what, reactions, treatment etc):

Date of last tetanus injection:

Immunisations current:

Has the athlete recently recovered from any illness or operations?  Yes  No

If yes, please give details:

Does the athlete have a communicable disease or has he/she recently been in contact with, anyone with a communicable disease (eg: chicken pox, measles, hepatitis)? *(This information will remain confidential to event staff)*  Yes  No

Please give details:

Please attach any additional information that could assist our staff or volunteer supporters to help the athlete enjoy their experience. This might include their usual assistance/support routines, travel sickness, sleep routines, hay fever, allergy to bee stings, other equipment required etc.

If the athlete has any EMERGENCY ACTION PLANS please discuss this and provide a copy to your Team Manager.

**Thank you for taking the time to complete this information**

# Medication Details



I have read and understand the Independence Games Medication Administration Policy. I give permission for the Team Manager or the person designated by the Team Manager to administer medication as follows:

Name of Athlete:

Signed (Parent or guardian):

Date:

Medication / Procedure	Delivery Method	Dosage Amount	Dosage Times	Medication Administrator to Initial					
				Given 15/4		Given 16/4		Given 17/4	
1.			AM:						
Notes: eg before food			Noon:						
			PM:						
			Bed:						
			Other:						
2.			AM:						
Notes: eg before food			Noon:						
			PM:						
			Bed:						
			Other:						
3.			AM:						
Notes: eg before food			Noon:						
			PM:						
			Bed:						
			Other:						
4.			AM:						
Notes: eg before food			Noon:						
			PM:						
			Bed:						
			Other:						
5.			AM:						
Notes: eg before food			Noon:						
			PM:						
			Bed:						
			Other:						