Fitness to Participate Form Confidential

School Name: _____ Year Level: _____

Name of Participant: _____ D.O.B. _____

Specific Medical Condition: (e.g. Asthma, Allergies, Epilepsy, Diabetes): _____

Notes to treating doctor

This patient is scheduled to participate in an Outdoor Education program and has self-identified a pre-existing medical condition on their medical form.

The Outdoor Education program in question is delivered in a 'semi-wilderness' setting, meaning that professional medical care may be from one to six hours away. Participation in the program involves regular physical exercise. Activities may include: bushwalking (carrying packs), camping, cycling, rock climbing, rafting, canoeing. We operate in all weather conditions. Should you require any further information about the program, please contact us at (03) 9035 7700.

Program staff hold Wilderness First Aid qualifications (either three- or seven-day minimum, depending on remoteness from professional medical assistance). This training is based on assessing and treating a patient in a remote or wilderness setting (more information available at http://www.wms.org/).

Doctor to complete:

Based on the information above and the patient's condition, we ask that you decide on this person's suitability to participate in the upcoming outdoor program. If approved, please include specific treatment protocols to follow in the event of an emergency.

Do you approve this participant attending an Outdoor Education program, based on their current medical condition, coupled with the demands of the program?

☐ Yes ☐ No

What treatment protocol are you willing to authorise for this patient in the case of a medical emergency while in a remote location (i.e. one or more hours away from medical care)?

_____
_____
_____
_____
_____

What should the staff managing this participant in the field be informed/aware of, in regards to the particular situation for this patient? What are the recommended parameters (if any) for participation in program activities?

_____
_____
_____
_____
_____

Name of Doctor: _____ **Phone:** _____

Signature of Doctor: _____ **Date:** _____

I give permission for the University of Melbourne to retain this form for statutory archival requirements, noting that I can access it by appointment, if required.