1SQN/03 Change Of Details Form

This form must be kept in Cadets' Personal File and updated quarterly.

PART A

Date Completed: DAY / MONTH / YEAR

Name: _____ Initial: _____ Rank: _____

Address: _____

_____

Home Phone: (04) _____

Cell Phone: (02) _____

Email: _____

School & Year: _____

Parent/Caregiver Details:

Primary

Name: _____

Address: _____

_____

Home Phone: (04) _____

Cell Phone: (02) _____

Email: _____

Secondary:

Name: _____

Address: _____

_____

Home Phone: (04) _____

Cell Phone: (02) _____

Email: _____

PART B

HEALTH PROFILE / MEDICAL HISTORY

The profile is designed to keep the records up-to-date and the unit personnel safe.

Cadet Full Name _____ Medic Alert Number _____(if applicable)

1 Please tick if you have any of the following

Asthma	☐	Travel sickness	☐	Heart condition	☐
Diabetes	☐	Fits of any type	☐	Chronic nose bleeds	☐
Epilepsy	☐	Dizzy spells	☐	Migraine	☐

Other (please specify) _____

2 Are you currently taking any medication? YES/NO

If YES, please state: Ailment/s _____

Name of medication/s _____

Dosage and time/s to be taken _____

Other treatment _____

3 Have you had any major injuries (breaks or strains), or illness (glandular fever etc) in the past 6 months that may limit full participation in any activities? YES/NO

If YES, please state the injury/illness _____

4 Are you allergic / react to any of the following?

	Yes	No	Please specify and include treatment
Insect bites / stings	☐	☐	_____
Food	☐	☐	_____
Prescription Medication	☐	☐	_____
Other allergies?	☐	☐	_____

5 Date of last tetanus injection? _____

6 What pain/flu medication may be given if necessary? _____

7 To the best of your knowledge, have you been in contact with any contagious or infectious diseases in the last four weeks?

YES/NO

If YES, please state _____

8 State any dietary requirements_____

_____

9 Family Doctor _____ Phone _____

Address _____

_____

I agree that if prescribed medication needs to be administered, a designated staff member/s will be assigned to do this. I will inform the Squadron as soon as possible of any changes in the medical or other circumstances between now and the commencement of the activity.

Printed Name _____ (Parent / Guardian)

Signed _____

Date _____