Council for Aboriginal Alcohol Program Services
Aboriginal Corporation

CAAPS

General Medical Consent (Unaccompanied Minor)

Client Information		
Family Name	Given Name	
Date of Birth __/__/____	Gender (circle) Male Female	
Medicare Number	Health Care Card Number	
Guardian Information		
Is the client under a current care order with the Minister? No Yes		
Guardian name	Relationship to child	Phone W: H: M:
Emergency Contact (additional to guardian details)		
Name	Relationship to child	Phone W: H: M:
Medical Details		
Known allergies _____ _____ _____ Is the client medicated? Yes No	Dietary restrictions Date of last tetanus injection __/__/____	

Current medication

Name	Dose	Time	Reason for medication
1.			
2.			
3.			

Does the client have any medical condition, physical or psychological limitations or cultural restrictions which may affect her/him taking part in the program and/or activities? Please provide full details (attach information if necessary). Please provide any other information which you believe may help staff provide the best possible care.

_____
_____
_____

Please read the following important points:

- All Clients will receive an initial medical consultation as soon after admission as practical
- All medications are stored securely on CAAPS premises and staff assist clients with any required medication as prescribed by a medical doctor
- Clients will be transported to medical appointment in CAAPS vehicles.

Consent		
Permission is given to seek medical attention in case of illness/accident whilst in the program	YES	NO
Permission is given for staff to administer first aid and medication if required	YES	NO
Permission is given for my child to attend medical appointments and undertake treatment whilst in the program	YES	NO
Permission is given for my child attend and undertake dental treatment required whilst at CAAPS	YES	NO
Permission is given for staff to transport clients in CAAPS vehicles	YES	NO
Permission is given for my child to undertake pathology testing (e.g. blood test) if required by a doctor	YES	NO
Permission is given for CAAPS staff to assist my child with taking prescribed medication if required.	YES	NO
Permission is given for my child to be provided with Paracetamol for temporary pain relief	YES	NO

Name: _____Signature: _____Date:__/__/__