

Kidney Health Australia National Kidney Kids Camp 2012

Name: _____

Medical Consent

I authorise staff and volunteers at the National Kidney Kids Camp to obtain medical assistance and treatment, including blood transfusion and anaesthetic, in an event of an accident. I agree to pay all medical and related expenses, including ambulance costs, incurred on my behalf.

Signature: _____ Date: _____

Photo/Video & Media Release Consent

I hereby consent to photographs and video coverage being taken of me on the National Kidney Kids Camp 2012 for the discretionary use of KHA.

I agree that Kidney Health Australia and/or their approved sponsors, partners and other agencies may use this material (or any copies of it) for publication/advertising now or in the future. This consent is based on the understanding that Kidney Health Australia before giving approval to partners/advertising sponsors/agencies requires all of the potential users to provide written details and examples as proof of how the image will be used, who the audience is and any accompanying text/copy.

If the material is used for Kidney Health Australia fundraising purposes, I realise that all monies go to Kidney Health Australia, not specifically to myself and I further acknowledge that I have no:
- claim to royalties with respect to; or
- intellectual property rights in:
any material contemplated by this section.

I understand that there is a possibility that the footage or photographs taken may not be used.

Signature: _____ Date: _____

Declaration

By signing this form I, the undersigned, affirm that I have read the **Volunteer Information & Guidelines** as outlined by Kidney Health Australia (KHA) and that I agree to abide by them in full. I also understand that my application will be unsuccessful if I do not agree to abide by these conditions. Should I not abide by any of the conditions I understand that I may be dismissed and removed from the camp at KHA's discretion.

I warrant that the information in this form is accurate as at the date of signing.

Signature: _____ Date: _____

Thankyou for your support



Volunteer Application Form Kidney Health Australia National Kidney Kids Camp 2012

Personal Details

Surname: _____ Given Name: _____
Address: _____
Suburb: _____ State: _____ Postcode: _____
Phone: Day () _____ Night () _____ M/F
Mobile: _____ Email: _____

Do you hold a current license? Yes /No

If **YES**, please indicate the number of years you have held this license: _____

Are there any conditions on your license? (E.g. Glasses must be worn whilst driving, etc): Yes/No
If **YES**, please specify: _____

What is the nature of your license? (e.g. Standard, Heavy, etc): _____

I warrant that any vehicle I provide for transport at the camp is registered, roadworthy, well maintained and in good working order. It is fitted with seat belts and can carry _____ (enter number) belted passengers in addition to the driver.

Signature: _____ Date: _____

Complimentary T-Shirt: (Please Circle)

Small Medium Large X-Large

Photographs:

To assist with administrative purposes, we ask you to attach **1 STANDARD PASSPORT SIZED PHOTOGRAPH** to your application. Have you attached 1 passport sized photos? Yes/No

Availability

Are you available to assist throughout the whole camp (9 – 14 April)? Yes/No

If **NO**, please indicate the day(s) and time(s) you are available to assist.

APRIL 2012	Mon 9	Tue 10	Wed 11	Thur 12	Fri 13	Sat 14
AM						
PM						
OVERNIGHT						

Skills Profile

Please refer to the volunteer Information & Guidelines and indicate in which aspect(s) you would like to volunteer. You may wish to volunteer for more than one role. (Please Tick).

Team Leader Small Group Carer One-On-One Carer

Do you hold a current senior First Aid Certificate (or equivalent)? Yes/No

What is your reason/objective for wishing to volunteer at this camp?

What experience do you have with children?

What specific skills and experience do you believe you can offer to the camp?

Please add in any other information that you think would aid in your application.

Screening

Please provide contact details of 2 verbal referees who you have known for the past 2 years. Preferably not family members.

Referee 1:

Full Name: _____

Phone: Day() _____ Night() _____

Mobile: _____ Email: _____

Referee 2:

Full Name: _____

Phone: Day() _____ Night() _____

Mobile: _____ Email: _____

Do you have a current Working with Children Check or Blue Card? Yes/No

If **YES**, please attach a signed photocopy when returning your application.

Alternatively, do you consent to Kidney Health Australia obtaining a police check? Yes/No

*Please note we reserve the right to reject any application where such consent is refused.



Medical Insurance Information

Medicare Number: _____

Ambulance Fund Membership? Yes/No

Does you have Private Health Insurance? Yes/No

If **YES**, what is your:

(A) Private Health Fund Name: _____

(B) Private Health Fund Membership Number: _____

Medical Information

Allergies:

Do you have any allergies? Yes/No

If **YES**, please specify: _____

If **YES**, what special care is needed? _____

Diet Restrictions:

Do you have any diet restrictions? Yes/No

If **YES**, please outline: _____

Medical Conditions:

Please indicate if you suffer from **any** of the following: (Please Circle)

- | | | | |
|----------------|------------------|--------------|-----------------|
| Kidney Failure | Asthma | Dizzy Spells | Travel Sickness |
| Transplant | Epilepsy | Blackouts | Bed-Wetting |
| Diabetes | Fits Of Any Kind | Migraine | |

Other (please specify): _____

Tetanus Immunisation:

My last tetanus immunisation was: _____

Tablets & Medications:

At camp will you be taking any tablet(s) and/or medication(s)? Yes/No

If **YES**, please complete the medication chart below:

Name Of Drug	Dosage	Time Taken Each Day

By detailing tablets and medication, you agree that you, and only you, will take such medications and will keep these tablets and medications in a secure place during the camp. You agree to immediately report any missing tablets or medications.

Emergency Contact:

Full Name: _____

Phone: Day() _____ Night() _____

Mobile: _____ Email: _____

Family Doctor:

Full Name: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Phone: Day () _____ Night () _____