## SOMALI COMMUNITY INC. **DETAILS FORM**

For any assistance email: <a href="mailto:admin@somalicommunity.org.au">admin@somalicommunity.org.au</a>

<u>or</u> phone Farah: 0432677567

First Name:		
Surname:		
Home Address:		
Postcode:		
Phone: Email:		
Medicare number: Individual Reference No# (IRN)		
COVID Vaccination status: Fully vaccinated $\square$ Unvaccinated $\square$		
Are you and your family covered by insurance provided by Ambulance Victoria?		
Yes□ No□ (Please tick)		
Do you or any of your attending children have any medical/health problems (including allergies)?		
Yes□ No□ (Please tick)  If yes, please give further information below (for asthma please provide copy of asthma plan):		
Name of Doctor/Medical Service: Telephone:		
Any other details (medical specialists etc.):		
,		

Attending dependent information		
1. Child's name	Surname:	
Medicare no# (*only required if different than attending parent/guardian	n) IRN (required)	
Date of Birth:/	COVID Vaccination status: Fully vaccinated ☐ Unvaccinated ☐	
2. Child's name	Surname:	
Medicare no# (*only required if different than attending parent/guardian	) IRN (required)	
Date of Birth:/ name Surnan	COVID Vaccination status: Fully vaccinated □ Unvaccinated □3. Child's ne:	
Medicare no# (*only required if different than attending parent/guardian	n) IRN (required)	
Date of Birth:/	COVID Vaccination status: Fully vaccinated ☐ Unvaccinated ☐	
4. Child's name	Surname:	
Medicare no# (*only required if different than attending parent/guardian	n) IRN (required)	
Date of Birth:/	COVID Vaccination status: Fully vaccinated ☐ Unvaccinated ☐	
5. Child's name	Surname:	
Medicare no# (*only required if different than attending parent/guardian	n) IRN (required)	
Date of Birth:/	COVID Vaccination status: Fully vaccinated ☐ Unvaccinated ☐	
*If you require additional space for more children please let us know		
Emergency contact name:		
Relationship to attendee:		
Phone:	Work phone:	

## **Permission Agreement**

*I give all persons named above including children permission to attend the activities organized and arranged by Somali Community Inc. <b>Yes</b> No (Please tick)		
* In the case of an emergency, I authorize medical treatment to be given to persons named above including children. If it is not possible to talk to me, I agree that the worker in charge will make every effort to contact the emergency contact person(s) listed above. However, if they cannot be reached, I give permission to the worker in charge to take all persons named including children to the doctor or hospital to get medical help if it is needed. The doctor may give whatever medical or surgical treatment he or she believes is necessary. Yes No (Please tick)		
* I give Somali Community Inc. permission to use photographs taken during the course of organizes activities for the purposes of promotional materials, media reports and other publications. Yes No (Please tick)		
<b>Privacy statement:</b> The personal information on this form is being collected for the purposes of being provided to a doctor, paramedic or other health care professional in the event of an emergency. This information may be shared with the My Study Companion Homework Club partner organisations and funding bodies.		
I have read and agree with the conditions outlined in this document:		
NAME:		
SIGNATURE:		
DATE: / /		