

North Coast Fun Club

Biala Support Services Inc

DATE: ___ / ___ / ___

NAME: _____

PREFERRED NAME: _____

PHONE NUMBER: _____

DATE OF BIRTH: ___ / ___ / ___

MOBILE PHONE _____

EMAIL: _____

ADDRESS: _____

DOCTOR'S NAME: _____ DR PHONE: _____

ALLERGIES: _____

MEDICAL CONSENT: In the event of an accident or illness I authorise medical assistance be sought as necessary and any associated medical costs incurred or the costs of drugs etc. that may be required in relation to treatment be paid in full by me or the person I am responsible for.

Signature of authorised person 18 years or older: _____

Please print name of authorised person: _____ Date: ___ / ___ / ___

Relationship of authorised person to client (eg mother,sister etc.) _____

MEDICATION DETAILS

MEDICATION	DOSAGE	TIME TAKEN

~ Please inform Coordinator if there are any changes to medication/ dosage etc.~

Any person requiring assistance to take their medications needs to bring their medication clearly marked with the person's name, name of medication, dosage, dosage times and whether to be taken with or without food. A 'Webster' type pack is preferred. Staff are only permitted to assist with medications if this information is supplied.

SPECIAL DIETARY REQUIREMENTS: _____

SPECIAL NEEDS: _____

Contact Person Information

Biala Support Services Inc

DATE: ____/____/____

FULL CLIENT NAME: _____

EMERGENCY CONTACT

RELATIONSHIP TO CLIENT: _____

CONTACTS NAME: _____

ADDRESS: _____

HOME PHONE: _____

MOBILE: _____

EMAIL: _____

SECOND EMERGENCY CONTACT

RELATIONSHIP TO CLIENT: _____

CONTACTS NAME: _____

ADDRESS: _____

HOME PHONE: _____

MOBILE: _____

EMAIL: _____

OTHER CONTACT

RELATIONSHIP TO CLIENT: _____

CONTACTS NAME: _____

ADDRESS: _____

HOME PHONE: _____

MOBILE: _____

EMAIL: _____