

Activity Leader: Health Declaration and Consent

Human Resources

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|  **EMPL ID *(HR Only)*** |  |
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| Personal Details |
| Full Name |       |
| College/Service Unit |       |
| Work Area |       | Student ID *(if applicable)* |       |
| Email |       | Phone |       |

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| Fitness to lead field activity |
| **The University aims to ensure it has a workplace that is safe and that no person is placed in an environment or given tasks which will result in physical or mental harm. To assist us, please answer the following questions:** |
| **Have you ever had an injury or medical condition, including gradual process, which may be aggravated or contributed to by the field activity?** | Yes [ ]  No [ ]  |
| **Do you have a health condition which could put you or any other person at risk?** | Yes [ ]  No [ ]  |
| **Do you have any allergies that may be aggravated or contributed to by the field activity?** | Yes [ ]  No [ ]  |
| **Do you take prescription drugs or medication which may affect your ability to carry out effectively and safely the functions and responsibilities of an activity leader?** | Yes [ ]  No [ ]  |
| **Have you ever been hospitalised for a medical condition which may be aggravated or contributed to by the field activity and/or the responsibilities of an activity leader?** | Yes [ ]  No [ ]  |
| **Do you have COVID-19 or have recently been tested for COVID-19 and are awaiting test results?**  | Yes [ ]  No [ ]  |
| Please tick if you have any of the following and attach further information about how to manage it | [ ]  Seizures any type | [ ]  Epilepsy |
| [ ]  Migraine | [ ]  Diabetes |
| [ ]  Allergies (specify) | [ ]  Sleep walking |
| [ ]  Travel sickness | [ ]  Heart condition |
| [ ]  Mental health | [ ]  Asthma or respiratory condition |
| [ ]  Disability (specify): |
| [ ]  Infectious disease (specify): |
| [ ]  Fears/Phobias (specify): |
| [ ]  Other (specify):       |
| Do you require any regular medication which you will be taking on the field activity? *If yes, please detail. Use separate page, if req.)* | [ ]  No [ ]  Yes       |
| Medical condition requiring medication |       |
| Dosage and frequency |       |
| Doctor’s name |       |
| Medical Clinic name, address and phone no. |       |
| Do you have a community services card? | [ ]  Yes [ ]  No If yes, provide number: |
| Are there any other medical conditions, specific needs or things we should be aware of? |       |
| Provide details of any injury, medical condition or medications. *Please attach additional pages if you do not have enough room:* |
|       |

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| Next of Kin *(or emergency contact based within New Zealand)* |
| Name |  |
| Relationship to Activity Leader |  |
| Address |  |
| Phone(s) |  |

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| Information Privacy |
| **The information that you provide on this Health Declaration and Consent Form is collected for the purpose of assessing whether you have any pre-existing condition that may affect your ability to lead a field activity. This information will be disclosed only to duly authorised persons in the University. Information will be stored securely.****The University of Canterbury will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994, with regard to the collection, use and storage of the information released in accordance with this consent form.****You have the right to view this information at any time and request its correction.** |

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| Declaration and Consent |
| **I have truthfully completed all sections of this Health Declaration and Consent Form and have provided information that is accurate and complete to the best of my knowledge.****I acknowledge that circumstances change and that it is my responsibility to ensure all contact and medical information including medication is kept up to date.****In the event that I am required to undertake a medical examination by a Medical Practitioner or Occupational Health Physician, I give consent for the results of my examination to be released to the relevant parties within the University of Canterbury.** |
| Signature: Date:       |

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| Manager/Head |
| **I have reviewed this Declaration and Consent and give my approval for the activity leader to lead the field activity.** |
| Name:  |
| Signature: Date:       |

HRPF: FieldActivity