**PERSONAL DETAILS**

**Name:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_** **D.O.B:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Age:** **\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **P/code:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mobile:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_**

**Pronouns (She/Her; He/Him; They/Them: Other):** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CULTURAL & GENDER IDENTITY (Optional Questions)**

**Do you identify as Aboriginal or Torres Strait Islander?**

YES NO Prefer not to say

**Cultural background/ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_
Gender identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**EMERGENCY CONTACT**

Please provide the contact details of someone we can contact in the event of an emergency.

**Name of emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL INFORMATION:**

In the event of an accident and/or medical emergency, IYC staff may need to obtain medical assistance for you. Your personal health information is collected to assure your wellbeing & safety at IYC.

**Medicare number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health care card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you suffer from any allergies we need to be aware of?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently taking any medication? (If so, please specify):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**INFORMED CONSENT**

I consent to receiving support from IYC. I understand that as part of that support, IYC will collect my personal information, including my name, date of birth, address, phone number, email address, emergency contact and Medicare number.

I understand that this may also include sensitive information, such as ethnicity, sexual orientation, or criminal record. I understand that this information will only be collected to provide me with support. I understand that IYC may also use my de-identified sensitive information in research and funding applications.

 I consent

I understand that this consent will be valid for 12 months, and that I can choose to withdraw this consent at any time.

 I understand

**PHOTOGRAPHY/VIDEO CONSENT**

Innovation Youth Centre (IYC) may record images of young people for promotional purposes. These images may be used in mediums including media releases, publications, promotional material, and electronic media (Website, Instagram, Facebook).

IYC agrees not to provide photographs or video footage depicting young people to any other persons for their use unless with their consent and/or consent of their parent/guardian. IYC will retain the photographs and videos, but copies will be made available to you upon request.

I give IYC permission to use images taken of me in IYC publications and promotional material, broadcast, print & electronic media.

 I do not give IYC permission to use images taken of me in IYC publications and promotional material, broadcast, print & electronic media.

**EXTRA DETAILS (OPTIONAL)**

Do you identify as living with a disability?

**Yes No Unsure**

Do you attend any after school activities in the community?

**Yes No**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Medicare number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health care card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you suffer from any allergies we need to be aware of?**

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**Are you currently taking any medication? (If so, please specify):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**