



Youth Clicks Client Information

Please note the following information will be kept confidential.

Child's Information				
Family Name: _____		Given Names: _____		
DOB: _____		School: _____		
Address: _____ Suburb _____ P/C _____		Telephone: _____ Email: _____		
		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Parent/Guardian Information				
Mother's / Guardian Name: _____		Father's / Guardian Name: _____		
In Case Of Emergency: Contact 1 _____ Relationship: _____ Phone: _____ Mobile: _____ Email: _____ Address: _____ Suburb _____ P/C _____		In Case Of Emergency: Contact 2 _____ Relationship: _____ Phone: _____ Mobile: _____ Email: _____ Address: _____ Suburb _____ P/C _____		
Non English Speaking Background:		Is the child of Aboriginal or Torres Strait Islander background?	YES	NO
Religion:				
Young Person's Medical Information				
Medicare #:		Allergies:		
Family Doctor:		Doctors Phone:		
Dietary Requirements:		Asthma:	YES NO	
Medication:		Dosage:	Taken when:	
Does your child have any medical conditions? If <u>YES</u> , please provide a brief description of how it is treated			Yes	No

