



ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH RETREAT

2011

APPLICATION FORM

ALL APPLICATIONS CLOSE ON FRIDAY 9 December 2011

A copy of this form **must** be completed for **every** person attending, including children, presenters and workers.

Name: _____

Address: _____

Phone: (h) _____ (w) _____ (m) _____

Email: _____

Date of birth: _____

In case of an emergency, who do you want us to contact?

Name: _____

Relationship to you: (e.g mother, partner) _____

Their contact details:

Phone: (h) _____ (w) _____ (m) _____

Do you identify as (please tick)

- Aboriginal
- Torres Strait Islander
- Aboriginal and Torres Strait Islander
- Non-Indigenous

Are you (please tick)

- Living with HIV
- A partner/carer/family member of a person living with HIV who will be attending.
If yes, who _____

Do you have any food allergies/or requirements? eg diabetic (Please circle) Yes/No

Any mobility restrictions? eg wheelchair, or walker (Please circle) Yes/No

Do you have any current medication/medical requirements that ACON needs to be aware of during the Retreat? If so, please list them here. (Please circle) Yes/No

In case of emergency

Your current doctors' name and phone number:

Name: _____ Phone: _____

Is there any other information we need to know to assist us in organising your stay at the retreat? (Please circle) Yes/No

If you are traveling from outside of Sydney will you need transport from the railway station or airport to ACON? (Please circle) Yes/No

If you have other transport concerns please contact us as soon as possible on (02) 9206 2042.

Photo Consent

Photographs will be taken by the organisers as a record of our retreat. You do not have to appear in them if you do not want to. You are free to withhold consent. Copies of the photographs will be made available to participants who request them.

I consent to having my photo taken at the retreat (Please circle) Yes/No

Participation agreement

I understand and agree that I am responsible for my own participation at all times. I will notify the organisers if I am not well enough to participate in any activity during the retreat. I understand and agree that I am also responsible for any children under 16 that I bring to the retreat. I accept the health retreat is **ALCOHOL AND RECREATIONAL DRUG-FREE AT ALL TIMES.**

Signed: _____

Date: _____

Parental consent for participants under 16:

Signed: _____

Date: _____

Confidentiality agreement

I (insert name) _____
recognise that as a participant of the Health Retreat, I may learn certain facts and have access to information of a highly personal and confidential nature.

I understand that information of a personal and confidential nature includes medical conditions and treatment, sexual orientation, relations with family members, names of individuals with HIV/AIDS and their family and friends and other identifying information.

I agree that I will not discuss the content of this information or disclose information of a personal or confidential nature to anyone else.

I understand that if I breach an individual's confidentiality, that person is entitled to sue me for damages and that ACON will not indemnify me for such damages.

Signed: _____

Date: _____

IMPORTANT NOTICE

Section 17 of the Public Health Act 1991 (NSW) states:

A person who, in the course of providing a service, acquires information that another person:

- (a) has been, or is required to be, or is to be, tested for HIV/AIDS; and
- (b) is, or has been infected with HIV/AIDS,

must take all reasonable steps to prevent disclosure of the information to another person (except where the person to whom the information relates consents to disclosure). Breach of this provision is a criminal offence punishable by a fine of up to \$5500.00

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Please send completed applications to:

**ACON Aboriginal Project
PO BOX 350
DARLINGHURST NSW 1300**

Or Fax to:

ACON Aboriginal Project (02) 9206 2069