REVIVE
MEDICAL + CONSENT FORM

IMPORTANT: This form is designed to be completed collaboratively by the ACC Lead Provider and Client. This can take 40 minutes to complete. Once completed, email to anneke@adventurespecialties.co.nz.

PROGRAMME NAME: Revive

PROGRAMME START DATE: _____

ACC LEAD PROVIDER/THERAPIST

Lead Provider's name: _____ Lead Provider's p**hone:** _____

Lead Provider's email: _____

PARTICIPANT DETAILS

First Name: _____**Surname:** _____

Address: _____ **Post Code:** _____

Participant's Phone: _____ **Participant's email:** _____

Date of Birth: _____ / _____ / _____

Age: 4–0 ☐ 5–9 ☐ 10–12 ☐ 13–18 ☐ 19–25 ☐ 26–45 ☐ 46-65 ☐ 66+

I identify my Gender as: ☐ Female ☐ Male ☐ Gender Diverse / Preferred pronouns_____

Ethnicity: ☐ NZ European ☐ Other European ☐ Māori ☐ Asian ☐ Pasifika ☐ Indian ☐ African
☐ Latin American ☐ Middle Eastern ☐ Other _____

Iwi (if applicable): _____ **Country of Birth:** _____

Which Region do you live in? **Auckland:** ☐ Central ☐ North ☐ South ☐ East ☐ West
Canterbury: ☐
Rest of New Zealand: ☐ Please specify _____

Please note: All personal information will be used for statistical purposes only. No names will be used in any reporting.

PARTICIPANT'S STRENGTHS AND GOALS

What are your reasons for choosing this REVIVE Adventure Therapy programme?

THERAPEUTIC GOALS: What are your current therapy goals? How do you see the REVIVE programme as relevant to supporting these goals?

STRENGTHS AND PROTECTIVE FACTORS: What are some of your strengths?

Client's perspective:

Therapist's perspective:

PARTICIPANT'S SAFETY

Please let us know (by ticking the relevant box) if any of these safety areas are currently a concern:

	NO RISK	MILD RISK	MODERATE RISK	HIGH RISK
Violence	☐	☐	☐	☐
Deliberate self-harm	☐	☐	☐	☐
Suicide	☐	☐	☐	☐
Drug or Alcohol use	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Dissociation*	☐	☐	☐	☐
Triggers**	☐	☐	☐	☐

*Dissociation impacting on participation or ability to follow instructions

**Triggers leading to panic or impacting on participation or ability to follow instructions

STRATEGIES FOR MANAGING ADVENTURE THERAPY SESSIONS

What are some common triggers that you experience?

Please include an places or activities that could be triggering for you

What strategies do you use that help manage these triggers?

What plan have you thought through (with your therapist) for what to do, if you become triggered while on programme with us?

What advice would you give to our Clinician and Outdoor Instructor that might help you manage things you might find difficult?

FURTHER INFORMATION

Is there anything else you want us to know/anything you think would be important for us to know about you, before you attend our programme? For example: personality, safety, background, learning needs, Care and Protection, legal orders, confidentiality, etc.)

ACC LEAD PROVIDER'S ASSESSMENT

Please comment on your assessment of your client's stability and suitability for this programme. Do you have any concerns about their participation or safety while on this programme? What is your advice about how we can best support your client during the programme?

CONTINUATION OF THERAPY: This Adventure Therapy programme has been designed for ACC SCS clients to participate in, while simultaneously continuing their therapy with you/their Lead Provider.

Please sign below to confirm that you will continue to assess the stability of your client during our programme, and you will communicate with our Adventure Therapy Clinician if you have any concerns or advice, or if you observe any changes to your client's ability to safely participate in this programme.

Lead Provider signature: _____ Date: _____

PARTICIPANT'S EMERGENCY CONTACT

First Name: _____ **Surname:** _____

Cell Phone: _____ **Alternative phone:** _____

Relationship to Participant (e.g. Parent/Support Person): _____

PARTICIPANT'S HEALTH INFORMATION

Are you affected by:

Allergies	☐ Yes ☐ No	Impaired vision	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Heart complaints	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Poor balance	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Impaired Hearing	☐ Yes ☐ No

Other _____

If **"Yes",** please elaborate. Please also supply all relevant information about any medication you are on.

_____

_____

_____

Do you have any mental health needs that our staff should be aware of? ☐ Yes ☐ No

If **"Yes"**, please elaborate and supply relevant information about any medication that you may are on and the best way to support you while on the programme.

_____

_____

_____

Do you have any further things our staff should be aware of (physical, social, behavioural or mental health) that could influence your experience and/or participation on the programme?

_____

_____

_____

Would you like our staff to keep and administer any personal medication you are on? ☐ Yes ☐ No

Are you confident in water?	☐ Yes	☐ No
Are you able to swim 200m non-stop?	☐ Yes	☐ No
Are you able to walk 30 mins non-stop?	☐ Yes	☐ No
Can you ride a bike?	☐ Yes	☐ No

DIETARY REQUIREMENTS

Do you have any dietary requirements (for programmes where food is provided)? ☐ Yes ☐ No

If "Yes", please elaborate:

_____

_____

_____

PHOTOGRAPHS

In order to protect the privacy of all participants, Adventure Specialties Trust will take no photos of participants during this Revive Programme. You are welcome to take photographs of scenery or equipment/gear, our facilitators, and yourself, but **we ask that you don't take any photographs of other participants**. We are happy to take photos of you on your own phone or camera, (when we can) as a way to provide memories and capture your special moments on programme.

PLEASE TICK: I agree to this policy ☒ Yes ☐ No

DATABASE

Adventure Specialties Trust (AST) sends out a 3-monthly e-newsletter with photos, videos, stories, upcoming programmes and other news. Can we add your contact details to our database?

PLEASE TICK: I give permission for AST to add me to their database

☐ Yes (participant) ☐ Yes (Lead Provider) ☐ No, don't add me/us

CONTACT US

If you have any questions or concerns, please don't hesitate to contact us:
Adventure Specialties Trust / Lives Inspired by Adventure / www.adventurespecialties.co.nz
Head office: office@adventurespecialties.co.nz / (09) 837 6033
Auckland programmes: jeff@adventurespecialties.co.nz / (09) 837 6033 / Unit 1, 4 Winston Place, Henderson
Christchurch programmes: chch@adventurespecialties.co.nz / (03) 348 4547 / 71 Bamford Street, Woolston

Compliments or Complaints

If you would like to give us feedback, we would appreciate hearing from you. If you are unhappy with any part of our programme (staff, safety, the delivery of this programme) please contact us by emailing office@adventurespecialties.co.nz and we can discuss our complaints procedure with you. Your experience is important to us.

TERMS AND CONDITIONS

Safety and Risks

Adventure Specialties Trust delivers a wide range of adventure activities that may involve heights (abseiling, rock climbing), water (ocean, lake, river), remote locations, tight spaces (caving), cycling (road and mountain biking), physical and emotional exertion, and driving (transportation to and from activities).

We prioritise safety. We are registered with WorkSafe as an *Adventure Activity Provider.* We are audited under the *Adventure Activity Regulations* by AdventureMark, New Zealand's largest adventure certification body. We have a comprehensive Safety Management System in place which includes risk management, safe operating procedures, and appropriate staff deployment.

Despite these precautions, it is important to acknowledge that adventure activities inherently carry risks, and total safety cannot be guaranteed. Serious, life-changing events or even fatalities are possible, including but not limited to drowning, falls from heights, motor vehicle accidents, collisions while cycling, and natural hazards such as volcanic activity, avalanches, rockfalls, landslides, and extreme weather events.

Additionally, due to the active and outdoor nature of our programmes, minor injuries such as insect bites, grazes, and sprains may occur from time to time.

By signing this form, you acknowledge and accept that there is a degree of risk to you and/or your child's safety. You also agree that you and/or your child will do your part to help manage these risks by following all safety instructions. If these instructions are not followed, you and/or your child may be excluded from the activity.

Medication

I authorise Adventure Specialties Trust to administer the following medications as required and within the manufacturer's guidelines: paracetamol and/or ibuprofen (for pain relief), loratadine (antihistamine for mild allergic reaction), loperamide (for acute diarrhoea) and salbutamol (inhaler) for asthma.

In the event of an accident or illness, I authorise the obtaining of such medical assistance as may be thought necessary by the staff of Adventure Specialties Trust at my expense. This may include administration of adrenaline, salbutamol and promethazine as per Standing Order for suspected anaphylactic shock or aspirin for a suspected heart attack.

Dietaries

AST will make reasonable efforts to accommodate various dietary needs but cannot be held liable for anything, including potential cross-contamination that may lead to adverse reactions.

Damages

I agree to reimburse the cost of any deliberate or malicious damage caused to private or public property, including (but not limited to) that which belongs to Adventure Specialties Trust.

SIGNATURE

By signing below, I confirm that the information I have provided in this form is true and accurate. I confirm that I have read, understood, and agree to all the Terms and Conditions described in this document.

Signature of Participant: _____

Date Signed: _____