

Student's Name:

Care Group:

Address:

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Postcode:

Phone (Home):

Mobile:

Medicare No:

Emergency Contact:
(please include name of contact)

I consent to my child participating in:

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I also authorise the teacher in charge to consent, where it is impractical to communicate with me, to my child receiving such medical or surgical treatment as may be deemed necessary (the cost to be borne by the parents).

MEDICAL INFORMATION

Please indicate if any medication is required.

		INFORMATION
Medication Required/Carried	YES/NO	
Heart Problems	YES/NO	
Respiratory Problems	YES/NO	
Allergies (e.g. Bee Stings/Hay Fever)	YES/NO	
Blood Pressure	YES/NO	
Phobias (e.g. Confined Spaces/Heights)	YES/NO	
Operations (Recent)	YES/NO	
Illness (Major/Recent)	YES/NO	
Epilepsy	YES/NO	
Diabetes	YES/NO	
Vision or Hearing Problems (e.g. Glasses, Hearing Aids)	YES/NO	
Asthma	YES/NO	
Other Relevant Conditions (e.g. ADHD, Dermatitis)	YES/NO	
Drug Reactions (e.g. Penicillin Allergy)	YES/NO	

ADDITIONAL INFORMATION:

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Parent/Caregiver Name:

Signature:

Date:/...../.....