

STUDENT MEDICAL CONSENT FORM

PLEASE COPY BACK TO BACK

SURNAME:

School _____ Given Name _____ Surname _____ Home Address _____ Home Phone _____ Work/ Mobile Phone _____	MALE or FEMALE Date of Birth _____ Post Code _____	Medicare Details  Medicare Number _____ Number of person _____ Medicare Exp Date _____
Name of Family Doctor _____ Phone Number _____		

Emergency Contact _____ Relationship to Student _____ Phone _____

Is your child arriving late or departing early from camp? **YES/NO** If YES, please complete the following details:

Day/Date	Arrival Time	Reason for late arrival/early departure	Departure time	Return Time	Day/Date

*Please indicate **YES or No** if your child has one or more of the following conditions that may affect their health and safety to fully participate during the camp. If YES, please write details of the condition to assist camp coordinators in supporting your child.
 If your child has a health condition requiring an individual and/or emergency health plan (IHP/EHP) or Action Plan which caters for the conditions of this school camp, please attach a copy of these to this form.*

Diabetes	YES NO _____	Asthma/ Other respiratory problems	YES NO _____
Epilepsy	YES NO _____	Sinus and/or Hay Fever	YES NO _____
Special Learning Needs (ADHD, Autism etc)	YES NO _____	Sleep Walking	YES NO _____
Severe Allergy (Epipen required)	YES NO _____	Bed Wetting	YES NO _____
Physical Disability	YES NO _____	Had an infectious disease recently?	YES NO _____
Phobias	YES NO _____	Immunised; list vaccinations	YES NO _____

Medical Allergies (eg. Penicillin, analgesics)	YES NO	Tetanus Booster Last given:	YES NO
Food Allergies (Medically diagnosed eg. Coeliac, dairy, etc)	YES NO	Does your child wear: Glasses	
Special Dietary Requirements (Religious reasons, vegetarian, no pork etc)	YES NO	Contact lenses (soft/hard) Prosthetics	YES NO
Heart Condition/ recent operation/ injury	YES NO	Mouthguard Orthotics	
Other relevant information	YES NO		

In the case of a medical emergency every effort will be made to notify carers.

In the rare case that contact cannot be made please give authorisation for Qualified Practitioners to administer:

ANAESTHETIC (Please circle) YES NO BLOOD TRANSFUSION (Please circle) YES NO

Is your child taking tablets and/or other form of prescribed medication? **YES NO**

If YES, please complete the Authority to Administer Medication form available from your school and ensure the school has received the form. **School staff will not administer** any over the counter medication, including analgesics, homeopathic or prescribed medication unless a written request is provided from a parent/guardian, accompanied by written advice from a medical practitioner and with the medication in the original labelled container.

Are there any custodial issues that the Principal and/or camp staff should be made aware of? **YES NO**

If YES, please attach details in writing.

Please indicate your child's swimming ability (please circle) **Non-swimmer Weak swimmer (unable to swim 25m) Competent (can swim 25m)**

Any other additional details or conditions please outline:

CAMP CONSENT

I _____, give consent give consent for teachers/staff involved in the camp to provide basic first aid if required and/or contact an ambulance who will determine any additional emergency response required. I understand that all reasonable attempts will be made to contact me in the event of any emergency. I acknowledge that the Department of Education and Training does not have Personal Accident Insurance cover for students. I agree to pay all expenses incurred on behalf of the above student.

Signature of parent: _____

Print Name: _____

Date: _____