Permission/Medical Record (for all excursions/camps/activities)

This form is to be completed by parent/guardian of all students participating in excursions/activities carried out throughout the school year. These excursions/activities may include: day trips/camps/swimming/obstathon etc.

I hereby give permission for my child to participate in the excursion/activities as described in the letter sent home and agree to delegate my authority to the teachers involved. I shall notify the school if any medical details concerning my child changes throughout the year.

_____

Parent/guardian signature

Name of student:	**Date of Birth:**
Name of family Doctor:	**Phone:**
Medicare Number:	**Position:**

MEDICAL CONDITIONS: Please indicate below any **known medical conditions** relevant to the above-named student. Please describe the nature of the problem or provide a letter from your doctor. e.g. Allergies, Asthma, Drug Reaction, Phobias, Epilepsy, Operations, Heart Problems, Blood condition, Other…	**COMMENTS: Condition, symptoms, treatment etc explained below:**
IMPORTANT: My child DOES/DOES NOT suffer from asthma. Please attach your child's asthma action plan from your doctor and provide required medication (labelled).	
Date of most recent tetanus injection:	

CURRENT PRESCRIBED MEDICATION (S) The medication(s) listed below has/have been prescribed for my son/daughter by a registered practitioner and will be required to be administered while my child is involved in the excursion indicated in Section 1.

I hereby request the teacher accompanying the excursion who has been so authorised by the Principal to administer the medication(s) in accordance with the instructions written on the medication container(s) by the pharmacist in accordance with the medical practitioner's instructions. I understand that all unused medication(s) will be returned to me.

_____	_____	_____
Parent/Guardian Name	Signature	date

MEDICATION DETAILS AND TIMES OF ADMINISTRATION:		
NAME OF MEDICATION	QUANTITY OF MEDICATION	TIMES FOR ADMINISTRATION

Does your child have an action plan provided by your GP? Yes / No

- If yes, you **must** attach a copy of this with this enrolment and prior to enrolment start date.
  ☐ Copy attached

Does your child require the administration of regular medication? Yes / No

- If yes, you must complete an "Administration of medication at school record sheet" prior to enrolment start date.
  ☐ Form provided by the office, completed and attached

AUTHORITY:

I hereby authorise the supervising teachers to obtain any medical or associated assistance, which they deem necessary should any medical condition or accident occur.

I agree to pay any ambulance, medical, dental and/or pharmaceutical expenses incurred on behalf of the above student which are not covered by my personal/family ambulance subscription, medical benefits fund (or travel insurance in the case of overseas travel).

I further authorise qualified practitioners to perform surgery, administer anaesthetic and/or administer blood transfusions if such an eventuality should arise. I understand that, should such circumstances arise, the supervising teachers will endeavour to contact me by phone in the first instance.

_____ _____ _____

Parent/Guardian Name Signature Date

Phone No: _____ (home) _____ (work)

Mobile Phone No: _____

Please note: If any medical details change during enrolment please notify the school office 40678333 or email enrolments@babindass.eq.edu.au with all relevant information as soon as possible.