CONFIDENTIAL INFORMATION for SCHOOL CAMPS/OVERNIGHT EXCURSIONS

This information is intended to assist the College in case of any medical emergency with your child. All information is held in confidence.

STUDENT DETAILS

NAME _____

HOME ADDRESS _____

DATE of BIRTH _____ STUDENT CODE _____ Home Group _____

MOTHER/GUARDIAN _____ HOME № _____

MOBILE № _____ WORK № _____

FATHER/GUARDIAN _____ HOME № _____

MOBILE № _____ WORK № _____

FAMILY DOCTOR _____ PHONE № _____

MEDICAL SPECIALIST _____ PHONE № _____

MEDICARE № | | | | | | | | | | | *№ beside name*

AMBULANCE MEMBERSHIP YES / NO *Please circle*

MEDICAL/HOSPITAL INSURANCE FUND _____

CONTRIBUTION № _____

ADDITIONAL EMERGENCY NAME _____

RELATIONSHIP _____

CONTACT № _____

SWIMMING ABILITY GOOD / FAIR / POOR / NON-SWIMMER *Please circle*

EYESIGHT GLASSES / CONTACT LENSES *Please circle if your daughter wears either of these*

PREVIOUS EXPERIENCE YES / NO *Is this your daughter's first time away from home?*

DIETARY REQUIREMENTS

Please list details of ALL dietary requirements in the space below.

_____

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MEDICAL RECORD

Please tick if your child is living with any of the following health conditions.

☐ *Bedwetting* ☐ *Blackout* ☐ *Dizzy spell* ☐ *Heart condition*

☐ *Migraine* ☐ *Seizure of any type* ☐ *Sleepwalking* ☐ *Travel sickness*

☐ *Other (Please detail below)*

_____

_____

Please tick if your child has any of the following health conditions ***that require management plans****.*

☐ *Anaphylaxis* ☐ *Asthma* ☐ *Diabetes* ☐ *Epilepsy*

IF TICKED, PLEASE SUPPLY A COPY OF THE RELEVANT MANAGEMENT PLAN.

ALLERGIES *Please specify*

Bees/Wasps _____

Medications/Drugs _____

Foods/Plants _____

Other _____

Reaction & usual treatment _____

_____

TETANUS IMMUNISATION *Please specify the year of your child's last immunisation.* _____

TABLETS & MEDICINES *Is your child presently taking/using any medication?* **YES / NO**

If YES, please specify name/s & dosage _____

ALL medication must be handed to the teacher in charge prior to leaving.

ALL containers must be labelled with your child's name, the dose to be taken and when it should be taken.

If it is necessary or appropriate for your child to carry their own medication (e.g. asthma puffer), it MUST be with the knowledge and approval of both you and the teacher in charge.

CONSENT TO MEDICAL ATTENTION

Where the teacher in charge of the camp/excursion is unable to contact me, or it is otherwise impracticable to contact me, I authorise the teacher in charge to:

- Consent to my child receiving such medical or surgical attention as may be deemed necessary by a medical practitioner
- Administer such first aid as the teacher in charge may judge to be reasonably necessary

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

The Department of Education and Training requires this consent to be signed for all students attending school camps/excursions.