

STUDENT HEALTH & PERMISSIONS FORM



STRICTLY CONFIDENTIAL

This information is required for each student and will assist the schools and supervising staff in the preparation and planning of excursions and activities including classroom excursions and sporting events

STUDENT DETAILS

Student Name: _____ Room: _____

Date of Birth : ____/____/____

Parent/Guardian's full name/s: _____

Address: _____

_____ Post Code: _____

Contact numbers during school hours – i) _____ ii) _____

Email Address: _____

Alternative Contact if Parent/Guardian not available:

Name: _____ Telephone Number: _____

Name of Family Doctor: _____ Telephone Number: _____

PERMISSIONS

Photo permission **Yes (___) No (___)**

Permission to speak to the School Chaplain **Yes (___) No (___)**

MEDICAL DETAILS

Is your child subject to seizures, fainting, epilepsy, diabetes or any other condition that may affect his or her safety? **Yes (___) No (___)**

If "yes" please give details: _____

Is your child allergic to: (Please give details)

Penicillin **Yes (___) No (___)** _____

Any other drug **Yes (___) No (___)** _____

Any Food **Yes (___) No (___)** _____

Other **Yes (___) No (___)** _____

Date of Last Tetanus vaccination: _____

Medication

Does your child have a current Health Care Authorisation Plan at School? **Yes (___) No (___)**

Parents/Guardians are requested to make arrangements with the teacher-in-charge for the safekeeping and handling of medications prior to the excursion.

Is your child presently taking tablets and / or other forms of medication? **Yes (___) No (___)**

Does your child self-administer the medication? **Yes (___) No (___)**

If "yes", state name of medication, dosage and frequency of use:

Other Information

Please provide any other information about your child which will enable the organisers of the excursion to provide better care for your child:
