**ST. PATRICK'S PARISH SCHOOL, ALBURY**

**EXCURSION CONSENT AND MEDICAL INFORMATION FORM**

**(COMPLETION OF THIS FORM IS COMPULSORY)**

I _____ permit _____ _____ __/__/____
*(Name of Parent – printed)* *(Name of Student)* *(Class)* *(D.O.B)*

to take part in the **NSW Catholic Primary Schools Basketball Challenge, Goulburn, 17th, 18th and 19th November, 2017**

❖ I understand and agree with the activities and arrangements made for the Excursion. During the Excursion I delegate my authority to the Supervising Staff and/or Instructors involved in the Excursion. Such teachers or instructors may take whatever disciplinary action they deem necessary to ensure the safety, wellbeing and successful conduct of the students as a group and individually.

❖ In the event of illness or an accident that requires medical attention, I permit Supervising Staff to seek necessary medical attention on behalf of my child and I agree to be responsible for any costs incurred through such action.

❖ I further authorise qualified practitioners to administer anaesthetic if such an eventuality arises.

❖ I give permission for my child to be given a single dose of Panadol (tablet or liquid form) necessary for headache or slight pain.
NO [ ] YES [ ] *(Parent will be contacted if a second dose is needed)*

Signature of Parent_____ Date_____

Contact Phone Number: Home:_____Work:_____Mobile:_____

❖ Does your child have any medical condition/s or allergies that may affect his/her safety during the excursion? NO [ ] YES [ ]

_____

_____

❖ Does your child require medication during the excursion (tablets and/or medicine)? NO [ ] YES [ ]
If YES, please complete attached "*Administration of Medication Form*". (see over)

❖ All medicines must be handed to teacher-in-charge prior to leaving, with your child's name, the dose to be taken and when it should be taken. (These will be kept with the Teacher-in-Charge and distributed as required.) The Teacher-in-Charge may give some medications straight back to the children e.g. Asthma Puffers.

Students Medicare No: _____ No. on card: ____ Expiry Date: _____

Medical/Hospital Insurance Fund: _____ Number: _____ Exp Date: _____ Ambulance: Yes/No

Please tick if your child suffers any of the following:

Heart Problems ☐ Fits ☐ Blackouts ☐ Bed Wetting ☐ Dizzy Spells ☐

Respiratory Problems (including asthma) ☐ Travel Sickness ☐ Migraine ☐ Sleepwalking ☐ Other ☐

❖ If you have ticked any of the above, and your child requires medication or special treatment, please give details: (including asthma management plan)

_____

_____

❖ Date of Last Tetanus Injection: / / *If it is more than 10 years please tick if a booster is to be arranged by parents before the excursions.*

❖ Is this the first time your child has been away from home? NO [ ] YES [ ]

❖ Please provide any other information about your child which will enable the organizers of the excursion to provide better care for your student.

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