



# Manilla Central School

## Consent and Medical Information Form

### Year 7 Lake Keepit Camp

Thursday 9<sup>th</sup> & Friday 10<sup>th</sup> February 2023



*Please complete the following information and return to excursion coordinator by Monday 6<sup>th</sup> February 2023*

Child's Surname: ..... First/Given Names: .....

Address: ..... Suburb: ..... Postcode: .....

Age: ..... Yrs ..... Mths                      Date of Birth: ...../...../.....                      Sex: .....

Parent/Guardian Name in full (Block Letters): .....

Telephone: (Home): ..... (Work): ..... (Mobile): .....

Other contact person (in case parent/guardian cannot be contacted):

Name: ..... Telephone: .....

**MEDICAL INFORMATION: Important Note**

A. **ANY CHILD WITH A MEDICAL PROBLEM WHO IS PARTICIPATING IN THE EXCURSION SHOULD BRING A LETTER FROM HIS/HER DOCTOR REGARDING TREATMENT OF THE CONDITION.**

Information regarding severe asthmatics, diabetics and other urgent conditions should be given to coordinator. Medication taken on the excursion should have the child's name, dosage and dosage times clearly marked. Only medication in the child's name will be administered. Medication is to be handed by the parent to the coordinator.

B. Special dietary food ordered by a doctor must be sent with the child and/or discussed with the excursion coordinator.

**PLEASE ANSWER THE FOLLOWING QUESTIONS**

1. Is he/she in good health? Yes/No

2. Does your child suffer from any chronic illness or disability? Yes/No  
If the answer is YES, what is the nature? .....

3. Has he/she suffered from any acute illness during the past 4 weeks? Yes/No  
If the answer is YES, state the nature of the illness .....

4. Has he/she been treated by a medical practitioner during the past 4 weeks? Yes/No  
If the answer is YES, please indicate reason .....

5. Is he/she taking any mixture, tablets or any other form of medication at present? Yes/No  
If yes, please provide full details below or attach instructions from the prescribing doctor.

Name of Medication	Dosage	Times to be taken	Reason/Condition
.....	.....	.....	.....
.....	.....	.....	.....

**MEDICAL INDEMNITY**

I request staff of Manilla Central School to supply my child with the above medication and hereby indemnify the staff of Manilla Central School of any responsibility.

**Signed:** ..... (Parent/Guardian)

Date: .....

Please turn over

# Manilla Central School

## Consent and Medical Information Form (continued)

6. Child's current doctor: ..... Telephone: .....

7. Does he/she suffer from	(a) asthma*	Yes/No	(d) epilepsy, fits/blackouts	Yes/No
	(b) allergic reactions**	Yes/No	(e) skin conditions	Yes/No
	(c) diabetes	Yes/No	(f) sleepwalking	Yes/No

If **YES**, give full details of any necessary treatment: .....

.....

.....

\* *Please attach a current Asthma Action Plan for your child if applicable*

\*\* *Please attach a current ASCIA Action Plan for Anaphylaxis or Allergic Reactions if applicable*

8. Does your child have an allergy to any medications? Yes/No  
 If the answer is YES, give full details: .....

9. Has he/she had the combined Diphtheria, Tetanus & Pertussis (dTpa) vaccination? Yes/No  
 If the answer is YES, in what year was the last vaccination given? .....

10. My child will require travel sickness tablets which I have supplied. Yes/No

11. In the event that my child does suffer from general sickness or travel sickness during the excursion,  
 I do/do not (please delete) give my consent for him/her to be given a **travel sickness tablet**.  
 I do/do not (please delete) give my consent for him/her to be given **paracetamol**.  
 I do/do not (please delete) give my consent for him/her to be given **cold and flu medication**.  
 I do/do not (please delete) give my consent for him/her to be given **vomiting/diarrhoea medication**.  
 I do/do not (please delete) give my consent for him/her to be **driven** in a car by a member of staff if required

**Signed:** ..... (Parent/Guardian) Date: .....

12. **MEDICAL TREATMENT:** Your Medicare No. is required in order to receive immediate medical attention if this should become necessary.

Medicare No.: ..... Health Care Card No.: .....

Private Health Insurance Fund: .....Membership No.: .....

In the event of any accident or illness I authorise the obtaining of such medical assistance on my behalf that my child may require. I also undertake to pay medical fees and/or cost of drugs which may be incurred while my child is on the excursion.

**Signed:** ..... (Parent/Guardian) Date: .....

13. In the event of an emergency during school hours, please contact the school on 6785 1184. Students **may bring** mobile phones on the excursion however the school takes no responsibility for any loss or damage.