Consent and Medical Form

Swimming Lessons

Student's Full Name: _____

Yr Level: _____

Date of birth: _____

Address: _____

_____

This form is to give permission for your child to attend an excursion, camp or retreat and to provide medical information that might be needed in case of an emergency. *All information is collected in accordance with the privacy act.*

1. EXCURSION DETAILS

Location: Glenn Buchanon Swim School

Teachers: Classroom Teachers

Dates: Term 4 – Tuesdays, Thursdays, Fridays

2. EMERGENCY CONTACTS

Name	Relationship	Phone Business hrs	Phone After hours	Phone (Mobile)
1.	Student's doctor			
2.	Student's dentist			
Please include at least 2 contacts				
3	Parent/guardian			
4				
5				

3. MEDICAL INFORMATION

Medicare Number: _____

Private Health Fund: _____ Health fund number: _____

Please tick if your child suffers from any of the following:

❒ Travel Sickness ❒ Bed Wetting ❒ Fits of any type ❒ Sleep walking

❒ Heart Condition ❒ Dizzy Spells ❒ Migraine

❒ Asthma > ❒ Copy of Individual Management Plan attached/ Current plan held at school.

❒ Diabetes > ❒ Copy of Individual Management Plan attached/ Current plan held at school.

❒ Epilepsy > ❒ Copy of Individual Management Plan attached/ Current plan held at school.

Is there any other medical condition that the group leader should be aware of?

_____

_____

If you have ticked any of the above, please attach additional information describing the nature of the problem and provide a letter from your doctor.

Is your child allergic to:

❒ Penicillin ❒ Any other drugs _____
❒ Bites/Stings/ Animals _____
❒ Foods _____
❒ Other Allergies _____
❒ Anaphylaxis > Have you supplied an EpiPen? □ **YES** □ **NO**
❒ Copy of Individual Management Plan attached.

What special care is recommended: _____
_____
_____

4. MEDICATION

- If the student requires any medication in relation to medical conditions or allergies, you are required to provide it to be taken on the camp/retreat/excursion.
- Medication label must be current *(date and quantity on packaging must be relevant to excursion period)*
  All medicines must be handed to the teacher in charge prior to leaving. Medicine must have been prescribed by a doctor and be correctly labelled by your pharmacist. Over the counter medicines, will not be administered unless prescribed by your doctor.
- Medication will be kept by the teacher and administered as required.
- *Medication Permission Slip (see attached)* must include all medications.
- Please do not let your child keep medicine while on the camp/retreat/excursion.
- If it is necessary for the student to carry his/her medication eg. asthma inhaler, it **must** be with the knowledge and permission of both the parent and teacher-in-charge.

Paracetamol (e.g. Panadol, Herron, Panamax)
Only paracetamol which has been prescribed to your child will be administered and only in accordance with the instructions written on the medical container (by the pharmacist) in accordance with the medical practitioner's instructions.

5. CONSENT

a. Medical: In the event of an accident or illness, when it is impracticable or impossible to communicate with me, I understand that the teacher in charge will arrange such medical or surgical treatment as he/she may deem necessary.

I agree to pay any medical, dental and/or pharmaceutical expenses, emergency or other transport costs, incurred on behalf of the above student which are not covered by my family ambulance subscription, private health fund etc.

I further authorize qualified practitioners to perform surgery, administer anaesthetic and/or 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. I authorize my doctor as listed in (2) above to provide hospital authorities or qualified medical practitioner(s) additional information concerning any of the medical conditions identified in (3) above.

b. Participation: I consent to my child's participation in this camp/retreat/excursion(including travel). I have been informed by the school of the arrangements made for the conduct of this camp/retreat/excursion. I understand that the camp/excursion includes some activities that may involve some risk and that the group leader has assessed these risks.

c. Expenses: In the event of illness, injury or non-cooperation, I agree to pay any expenses which may be incurred, or to come and collect my child from the camp/retreat/excursion or medical facility.

Signature of Parent/Guardian: _____ **Date:** _____

STUDENT DECLARATION

I agree to observe the rules of the camp/excursion and to cooperate with the teachers throughout the camp/excursion.

Signature of Student : _____ **Date:** _____

School Camp/Retreat/Excursion
Medication Permission Slip

Student's Name:			**Date of birth:**	**Grade:**
Parent contact details :	*Name :*			
	H.	*W.*	*M.*	
2nd Contact details:	*Name :*			
	H.	*W.*	*M.*	

1. PRESCRIBED MEDICATION

The medications listed on this form have been prescribed for my son/daughter by a registered medical practitioner and will be required to be administered while my child is involved in the camp/excursion indicated on the *Camp/Retreat/Excursion Consent & Medical Form*.

I hereby request the school staff member accompanying the camp/excursion, who has been authorized by the principal, to administer the medications in accordance with the instructions written on the medical container by the pharmacist, in accordance with the medical practitioner's instructions.

Name of Medication	Dosage	Additional information
	As per medical practioner's instructions on label.	

2. ASTHMA MEDICATION (blue inhalers only)

☐ My child's carries an Asthma Reliever. (blue inhaler e.g. *Airomir*, *Asmol*, *Epaq*, *Ventolin*, *Bricanyl*)

All other Asthma medication, including other colour inhalers, must be included in *Prescribed Medication (1. above).*

Name of Medication	Dosage	Additional information
	As per pharmacy label.	

I understand medication may be administered by a school staff member who may not have received medical training.

I agree to collect any unused medication from the school. (*Medications will not be sent home with student)*

I give permission to the Principal to obtain relevant information from the Prescribing Doctor.

I understand that it is my responsibility to inform the Principal of any changes involving the administration of the medicine.

Signature of Parent/Guardian: _____ **Date :** _____