

Medical Information Form

Child's full name: _____ D.O.B: _____

Parent/Guardian contact details:

Emergency Contact Person:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone (work): _____ Phone (work): _____

(mobile): _____ (mobile): _____

(home): _____ (home): _____

Medical Details:

Medicare no. : _____ Name on card: _____

Private Fund no. : _____ Name on card: _____

Medical History: (please tick)

- Asthma Epilepsy Allergies Diabetes Travel sickness
 Dietary needs Other _____

Please provide any additional information regarding those ticked above:

Medications and correct methods of administration.

Child's last tetanus booster: _____

Medical consent:

Where the staff member-in-charge of the program/excursion is unable to contact me, OR it is otherwise impracticable to contact me, I _____ authorize the staff member in charge to

- Consent to my child receiving any medical or surgical attention deemed necessary by a medical practitioner as required, and I agree to meet any attached expenses.
- Administer such 1st aid as the staff person judges to be reasonably necessary.

Name: _____ Signature: _____ Date: _____