

## KIN KORA STATE SCHOOL EXCURSION PERMISSION / MEDICAL FORM



# EXCURSION: \_\_\_\_\_

### STUDENT DETAILS

Surname: \_\_\_\_

\_\_\_\_\_ Given Names: \_\_\_\_\_ Date of Birth: \_\_ / \_\_ / \_\_ M / F Class \_\_\_\_\_

I give permission for my child to attend this excursion. Parent Signature \_\_\_\_\_\_

I give permission for my child to view G and PG movies. Parent Signature \_\_\_\_\_

PARE	NT/CARER 1 DE	TAILS				
Title: _		Surname:	Given N	Names:		Gender: M / F
Work I	Location:		Work Phone No. (	)		
Family Phone Number: ( )			Mobile Phone N	umber:		
Relatio	onship to student:					
Signatu	are of Parent/Guard	lian:	Date:	_//_		
PARE	NT/CARER 2 DE	TAILS				
Title: Surname:		Given N	Given Names:			
Work Location:			Work Phone No. (	)		
Family Phone Number: ( )			Mobile Phone	Mobile Phone Number:		
Relatio	onship to student:					
Signature of Parent/Guardian:				/		
EME	RGENCY CONT	ACTS - Used in	cases where we are unable	to contact	you if your chil	d is ill or has had an accident.
PRIO Y	RIT NAME		RELATIONSHIP TO	STUDEN	Γ PHONE NU	MBERS
1					Home:	Work:
2					Home:	Work:
3					Home: Home:	Work Work
	EDICARE	NUMBER	R:		nome.	WOIK
Pos	ition Number:	eg. <u>0</u>	<u>1</u> Exp	oiry Numbe	er: /	/
Ple	ase tick Yes or No	o to the list below	w. If you tick Yes, please at	tach a shee	t with detailed i	nformation about the matter.
a)	Tetanus Booster	in the last 12 mo	nths Yes No	b) As	thma	Yes No
c)	Other respiratory	problems	Yes No		ug allergies	Yes No
e)	Other allergies		Yes No		gar Diabetes	Yes No
g) Recent operation, illness or injury			-	ilepsy	Yes No	
i)	Blood pressure		Yes No		art problems	Yes No
k) m)	Bed wetting Other, please list		Yes No Yes No	l) Tra	avel sickness	Yes No
,	_			1		
	AILS OF DOCT					
NAM	lE	AD	DRESS			PHONE NUMBER

#### **MEDICINES:**

Please give details of any medicines being taken by your child. Include dosage/frequency etc.

Medication	Time / Frequency	Dosage

School staff will not administer over-the-counter medication, including analgesics, homeopathic or prescribed medications unless they sight a written request from a parent/caregiver accompanied by written advice from a medical practitioner and with the medication in the original labelled container/package. The exception is the epipen and the reliever puffer, such as Ventolin, that is included for the emergency treatment of asthma under the guidelines.

Activities for this excursion include:

Is there any activity in which your child should not participate:

I understand that in an emergency, teachers/volunteers accompanying the excursion may be required to seek medical assistance for my child if they deem it necessary and I agree that I will bear responsibility and will pay for any costs incurred as the result. I authorise qualified medical practitioners to undertake all necessary emergency medical procedures, including administration of

□ Anaesthetic or calmative agents

□ Pain relieving medication

□ Blood transfusion

Parent/Carer's Signature

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date

#### NOTE: A COMPREHENSIVE FIRST AID KIT WILL BE TAKEN.

OFFICE USE ONLY						
DATE	TIME	ACTION				

#### **PRIVACY STATEMENT**

The Department of Education and Training (DET) is collecting the information on this form for the purposes of assisting departmental staff to fulful their legal duty of care to the students concerned.

Personal information collected on this form may also be disclosed to third parties where authorised or required by law. The information will be stored securely. If you wish to access or correct any of the personal information on this form or discuss how it has been dealt with, please contact the school in the first instance. If you have a concern or complaint about the way your personal information has been collected, used stored or disclosed, please also contact the school in the first instance.