

PERSONAL & MEDICAL INFORMATION FORM FOR EXCURSIONS / OUT-OF-SCHOOL ACTIVITIES

Student's Name	Class	Date of Birth
Home Address		Phone

Emergency Contacts				
Name	Relationship	Phone (Home)	Phone (Work)	Mobile

Doctor	Address	Phone
Medicare Number	Private Health Fund	Number

Medical Conditions	
Any acute illness in the past 4 months? Yes/No If Yes provide details:	
Tablets and Medicines	Is your child taking any tablets and/or medicine? YES / NO (Please include on the medication schedule)
Allergies & Action Plan	Drug (eg Penicillin)
	Bites/Stings (eg Bees)
	Food
	Other
Immunisation	Has your child had complete Tetanus immunisation? YES / NO If yes, what was the date of the last booster?

Special Dietary Requirements (medical)	
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Any other relevant information eg TRAVEL SICKNESS, bed wetting, sleep walking	
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In the event of accident or illness, when it is impracticable or impossible to communicate with me, I understand the teacher in charge will arrange such medical or surgical treatment as may be deemed necessary, including the use of an ambulance.

If my child requires prescription or non-prescription medication, I agree to provide the school with this medication in its original packaging in a sealed envelope clearly labeled with my child's name and dosage, together with written notification from your Doctor stating medication and dosage details.

Parent/Carer Signature Date

Child's Name _____ Class _____

Medical Condition _____

INCLUDE NAME OF MEDICATION AND DOSAGE AND DIRECTIONS IN TIMETABLE FOR ALL MEDICATIONS

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Morning/Breakfast	Morning/Breakfast	Morning/Breakfast	Morning/Breakfast	Morning/Breakfast
Morning Tea	Morning Tea	Morning Tea	Morning Tea	Morning Tea
Lunch	Lunch	Lunch	Lunch	Lunch
Dinner	Dinner	Dinner	Dinner	Dinner
Before Bed	Before Bed	Before Bed	Before Bed	Before Bed

ASTHMA PLAN (All medication must be clearly labelled and given to the teacher before departure)

PREVENTATIVE Name of Medication Dosage Time Administered	
TREATMENT Name (Ventolin, etc) Dosage Frequency	
SPECIAL INSTRUCTIONS IN CASE OF EMERGENCY	
ADDITIONAL INFORMATION	

I authorise a staff member of Singleton Public School to administer the medication to my child as listed above.

Signed:

Date: