Staff safety

DEPARTMENT OF EDUCATION

Confidential Medical Information for School Council approved School Excursions

(Please complete and return as soon as possible)

This information is intended to assist the school in case of any medical emergency with your child. All information is held in confidence. Name:

Date of Birth:

Address:

Postcode:

Emergency Telephone:

After Hours: Business Hours:

Name and Address of Family Doctor:

Medicare No:

Ambulance Membership:…….

Medical/Hospital Insurance Fund: Contribution No:

Please tick if you suffer any of the following:

± Fits of any type	± Heart condition	± Asthma
± Diabetes	± Dizzy spells	± Sleepwalking
± Blackouts	± Migraine	± Travel sickness

Other

Allergies to:

Penicillin: Other drugs:

Any foods:

Other:

What special care is recommended?

Tetanus Immunisation -Year of last tetanus immunisation .....

Tablets and Medicines – Are you presently taking tablets and/or medicine? YES/NO

IF YES, please state name of medication, dosage etc

CONSENT TO MEDICAL ATTENTION

I authorise the staff in charge of the excursion/tour to consent, where it is impractical to communicate with me, to receive such medical or surgical treatment as may be deemed necessary.

Signature: Date:

Any Other Information: