Petrie State School
STUDENT MEDICAL CONSENT FORM

Surname: _____ Given Name(s): _____

Date of Birth: _____ Religion: _____

Name of Parent/Guardian: _____

Address: _____

Telephone Number: (H) _____ (W) _____ (M) _____

Medicare Number: _____

CIRCLE EITHER YES OR NO AND GIVE FULL DETAILS BELOW

a) Tetanus booster in last 12 months	Yes / No
b) Asthma	Yes / No
c) Other respiratory problems	Yes / No
d) Drug allergies	Yes / No
e) Other allergies	Yes / No
f) Dietary needs	Yes / No
g) Sugar diabetes	Yes / No
h) Recent operations, illness or injury	Yes / No
i) Epilepsy	Yes / No
j) Heart Problems	Yes / No
k) Blood Pressure	Yes / No
l) Bed Wetting	Yes / No
m) Other – please list below.	Yes / No

If you circled **yes** for any of the above please provide details below.

_____

_____

_____

_____

If other medication is required indicate dose and application:

Medical Problem	Medication	Dosage	When to be Taken

Please give details of any medical/physical reason which would prevent your son/daughter from participating in any activities.

_____

_____

_____

I am aware of the program and the type of activities it involves. I give consent for my son/daughter to participate in the program and agree to delegate my authority to the teacher(s) involved. I further authorise the Principal, or his representative, to obtain such medical attention as may be deemed necessary and I understand I am responsible for the costs. I authorise qualified practitioners to administer anaesthetic and a blood transfusion if necessity arises.

Parent/Caregivers Signature: _____ Date: _____