



# INDIVIDUAL MEDICAL & PERMISSION FORM

## CONFIDENTIAL

Parents/Guardians should read and complete this form giving details about the child/young person.

The permission/indemnity sections should be carefully read and a response given in each section. Please read the privacy notice at the end of the form.

## STAR OF THE SEA YOUTH / CHILDRENS WORKERS

Our Lady Star of the Sea Youth/Children's workers are required to undergo child protection screening and training in safety and care procedures and duty of care.

## PRIVACY STATEMENT

The Our Lady Star of the Sea Gladstone Parish Youth Group is collecting personal information regarding your child's participation in this activity in order that the group can properly address any particular needs of your child while they are in our care. The information will only be accessed by persons authorised by the Star of the Sea Gladstone Parish. It will not be used or disclosed to any other persons or agency unless you have given permission, it is required by law or it is in the best interests of your child's health and welfare.

## PERSONAL DETAILS OF CHILD / YOUNG PERSON

Name of Child/Young Person:					
School Attended:			Year Level:		
Date of Birth:		Current Age:	Gender (please tick)	Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Address:			Mobile (if any):		
			Email (if any):		
Is English First Language? Yes <input type="checkbox"/> No <input type="checkbox"/>		If No What Language is Spoken at Home?			

## PERMISSION

I give permission for my child to attend/participate in this excursion/activity:	
Parents Signature / Date _____ / /	

## INDEMNITY

I consent to my child becoming a member of and taking part in the overall activities of this group.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I give permission for my child to be photographed or videotaped. I understand that the image may be displayed in Star of the Sea Gladstone website s or publications. I understand that my Childs name will not be published or linked with photographs.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I give permission for my child to be transported in church vehicles or private cars arranged by the leaders of the above mentioned group on the occasions when it is necessary.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I consent to information about my child being collected as required for activity specific permission forms and accident/incident report forms.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I understand that while every reasonable pre-caution will be undertaken to ensure the protection of my child, I hereby release Our Lady Star of the Sea Gladstone, authorized staff and volunteers from any liability in the event of any injury, accident, misfortune, damage or loss whatsoever that may occur to my child and/or their property while present or arising from claims in relation to my child's attendance at above activity, including transport to/from the venue and leaving the activity venue without permission. Yes <input type="checkbox"/> No <input type="checkbox"/>	

## PARENT/GUARDIAN 1 CONTACT DETAILS

Title:	Surname:	Given Name(s):	
Address:			
Home	Work	Mobile	
Email			
Is English First Language? Yes <input type="checkbox"/> No <input type="checkbox"/>		If No What Language is Spoken at Home?	

## PARENT/GUARDIAN 2 CONTACT DETAILS

Title:	Surname:	Given Name(s):	
Address:			
Home	Work	Mobile	
Email			
Is English First Language? Yes <input type="checkbox"/> No <input type="checkbox"/>		If No What Language is Spoken at Home?	



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## EMERGENCY CONTACTS – Used in cases where we are unable to contact you if your child is ill or has had an accident.

PRIORITY	NAME	RELATIONSHIP TO CHILD	PHONE NUMBERS	
1			Home:	Work:
2			Home:	Work:
3			Home:	Work:
4			Home:	Work:

## SUPERVISION RESTRICTIONS If you answer Yes, please provide details.

Are there any relevant legal or custody matters, or orders, current or pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are there any restrictions on the supervision of this child/young person?	Yes <input type="checkbox"/> No <input type="checkbox"/>

## MEDICARE

Medicare No:			
Position on card:		Expiry Number:	/ /

## DETAILS OF DOCTOR

Family Doctor:		Phone:	
Address:			

## MEDICAL INFORMATION

Please give details of any medicines being taken by your child. **(NOTE: we do not provide or administer medications, including non-prescription eg. panadol)**

Medication	Time / Frequency	Dosage

Please tick Yes or No to the list below. If you tick Yes, please attach a sheet with detailed information about the matter.

a)	Tetanus Booster in the last 12 months	Yes <input type="checkbox"/> No <input type="checkbox"/>	b)	Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>
c)	Other respiratory problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	d)	Back, Bone, Joint Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
e)	Allergies (food, drug, ointments, other)	Yes <input type="checkbox"/> No <input type="checkbox"/>	f)	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
g)	Recent operation, illness or injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	h)	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>
i)	Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	j)	Heart Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
k)	Bed Wetting	Yes <input type="checkbox"/> No <input type="checkbox"/>	l)	Travel sickness	Yes <input type="checkbox"/> No <input type="checkbox"/>
m)	Other (including phobias)	Yes <input type="checkbox"/> No <input type="checkbox"/>			

Please give details of any **problems – medical or physical** – which would limit your Childs full participation in any activity, including any food restrictions.

\_\_\_\_\_

I understand that in an emergency, workers/staff accompanying the excursion/activity 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 medical procedures, including administration of

- Anaesthetic or calmativ agents
- Pain relieving medication
- Blood Transfusion

Parent(s) / Guardians Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_