

CO.AS.IT. AFTER HOURS ITALIAN LANGUAGE PROGRAM

PLEASE CIRCLE: CARLTON/CLAYTON CENTRE

MEDICAL INFORMATION

(This information is to be provided by parents to assist the teacher(s) in the case of any medical emergency, which may arise. All information will be held in confidence)

Full Name of Student: _____
Date of Birth: _____ Year level at the day school: _____
Full Name of Parent/Guardian: _____
Address: _____ Postcode: _____
Telephone Contact: Home: _____
Business Hours: _____
Child's Mobile No: (if applicable) _____

Photo of student

Other Emergency Contact: _____
Name, Address and Telephone Number of Family Doctor: _____

Medicare No.: _____

Ambulance Fund Subscriber: YES NO

Does your child suffer from asthma?: YES NO

Is your child at risk of anaphylaxis?: YES NO

IF YES, COMPLETE AN ANAPHYLAXIS ACTION PLAN

Major illness or disability: _____

Does your child have any learning difficulties? YES NO

Does your child have any allergies?: _____

Does your child take any Medications?: _____

If your child requires special medication re: epipen, ventolin etc, please ensure your child has it in their possession at all times.

Allergies to medication: _____

Allergies to foods: _____

ACCIDENT DECLARATION

In the event of illness or injury to my child whilst attending the Co.As.It. After Hours Italian Program, I authorise the teacher(s) in charge of my child, where it is impracticable to communicate with me, to consent to emergency medical arrangements on my behalf as are deemed necessary by a qualified medical practitioner. Such consent includes anesthetics, blood transfusions and/or operations. NB: CROSS OUT IF CONSENT IS NOT GIVEN FOR ANY OF THESE PROCEDURES.

*Signature of Parent/Guardian: _____

Date: _____

OTHER IMPORTANT INFORMATION:

1. Please list adult/s who are responsible for taking or picking up student from classes:

2. Please attach any important information that may be relevant in regards to the supervision or safety of your child e.g. *intervention orders, family issues etc.*