



QPCYWA School Age Care Excursion Permission Form

Private & Confidential



THIS SECTION TO BE COMPLETED BY THE PARENT/GUARDIAN

MEDICAL FORM FOR STRENGTH 4 LIFE EASTER 2012

The purpose of this form is to provide a written source of information regarding individuals who are participating in activities provided by PCYC. The form is an important legal document which must be read, understood and signed by you before the child can participate in the activity. The form requires you to acknowledge certain matters relevant to the activity and the risks associated with participation in it. It also contains a waiver, release and indemnity in favour of PCYC.

This form must be completed, signed and received by PCYC prior to the activity commencing. If it is not, your child cannot participate in the activity. Should you have any queries in relation to the form please do not hesitate to contact us.

Parent/Guardian Name: _____ Relationship _____

Address _____

Day Telephone _____ Night Telephone _____

Name of Alternate Contact: _____ Relationship _____

Address _____

Day Telephone _____ Night Telephone _____

Other Emergency Details

Medicare number _____ Health Care Card _____

Private health cover details _____

1. Does the participant have any dietary requirements that need to be catered for?

2. Is there any custody related information we should be aware of?

3. What is the participants swimming ability? (please tick)

Unable to Swim Poor Good Excellent Not Sure

4. Does the participant have (or ever had) the following conditions?

| | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Damage | <input type="checkbox"/> Intellectual Disability |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Reactions | <input type="checkbox"/> Muscular Damage | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Phobias | <input type="checkbox"/> Sensory Disability |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other Recent Illness |

If you answered YES to any of the above, please provide details below. If the space provided is inadequate for a complete description, or there is any other condition or circumstance we should be aware of that is not covered here, please provide details on a separate sheet of paper and attach it to this form.



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5. Has the participant had a tetanus booster?

YES NO Date of last booster? _____
(please tick)

I/we the undersigned being the participant/parent/legal guardian of the above-named participant hereby certify that the medical and emergency details provided above are true and correct.

Parent or Legal Guardian _____ _____ ____/____/____
(if participant under 18) **Print Name** **Signature** **Date**

ACKNOWLEDGEMENT

I/we hereby certify that all details I have provided on this form are true and correct. I understand and agree that:

- this activity is 100% drug and alcohol free.
- safety is the highest priority and that behaviour which compromises safety is unacceptable.
- failure to follow instructions may result in exclusion from the activity and being sent home at my expense and that no refund will be provided.

I/we the undersigned being the participant/parent/legal guardian of the above-named participant hereby give permission for(participants name) to travel by motor vehicle and bus to participate in this activity.

I/we the undersigned being the participant/parent/legal guardian of the above-named participant, acknowledge that all activities entered into by myself/my son/my daughter/my ward contain an element of risk and I/my son/my daughter/my ward must take reasonable care whilst participating in activities.

I/we further authorise PCYC to obtain all necessary medical treatment which may be required by me/my son/my daughter/my ward including any anaesthetic or surgical attention which may be prescribed by an appropriately qualified medical practitioner. I/we acknowledge that the costs of any such treatment, including evacuation and transport, shall be my/the participant's responsibility solely.

I/we authorise PCYC to use photos/images of myself/my son/my daughter/my ward in any media release, website or promotional materials.

I acknowledge that I am responsible for meeting any costs incurred as a result of failing to attend at the program after travel arrangements have been confirmed.

Participant _____ _____ ____/____/____
(always required) **Print Name** **Signature** **Date**

Parent or Legal Guardian _____ _____ ____/____/____
(if participant under 18) **Print Name** **Signature** **Date**