

**Consent form**  
**“Come Spend the Day at Monivae”**  
**22<sup>nd</sup> March 2016**

Dear Parents/Guardians

Please complete the information on this page and the emergency contact and medical information document on the reverse side of this page; it is the parent/guardian's responsibility to alert the College to any changes to the accuracy of the information given on this document.

By completing this document you are consenting to your child attending and participating in the ‘Spend the Day at Monivae’ – 22<sup>nd</sup> March 2016. The activities have been outlined in the letter.

Student Name: \_\_\_\_\_

Permission to attend: \_\_\_\_\_

(Parent/Guardian Signature)

D.O.B. \_\_\_\_\_

Primary School attended: \_\_\_\_\_

Home Address \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

(Home)

(Business)

(Mobile)

Emergency Contact Name: \_\_\_\_\_

Relationship \_\_\_\_\_

Phone No. \_\_\_\_\_

Alternative Emergency Contact Name: \_\_\_\_\_

Relationship \_\_\_\_\_

Phone No. \_\_\_\_\_

***Please turn over.....***



**Please indicate any medical information, which should be known**

Is your child on any medication? YES/ NO If yes please give details:

***All medicines must be handed to the teacher in charge prior to leaving, with your child's name, the dose to be taken and when it should be taken. These will be kept in the First Aid centre and dispensed as required.***

Please indicate if your child suffers from any of the following:

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Dizzy spells    | <b>Allergies to:</b>                |
| <input type="checkbox"/> Travel sickness | <input type="checkbox"/> Any Foods  |
| <input type="checkbox"/> Fear of heights | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Drugs      |
| <input type="checkbox"/> Blackouts       |                                     |
| <input type="checkbox"/> Epilepsy        |                                     |
| <input type="checkbox"/> Asthma          |                                     |
| <input type="checkbox"/> Sleep walking   |                                     |
| <input type="checkbox"/> Migraines       |                                     |

Other

Special Care required

Name of Doctor (for emergencies)

Phone

Medicare Number:

Health Fund

Do you belong to an Ambulance Fund?  YES  NO

*I give permission for my child to attend the above excursion and I agree he/she will be subject to the direction and control of the persons conducting the excursion, and I expect my child to obey all reasonable rules governing safety and behaviour. In the event of illness or accident to my child, I will be notified as soon as possible but I authorise the person in charge, where it is impracticable to communicate with me, to consent to my child receiving such medical treatment (including the administration of an anaesthetic) as may be deemed necessary by a legally qualified medical practitioner. I understand that all reasonable care for the safety and health of my child will be taken by the persons in charge of the excursion. I agree to pay all fees and expenses incurred, including those for transportation and hospital accommodation.*

Parent/Guardian Signature:

Date

**Please complete and return this form to Monivae by Wednesday 16<sup>th</sup> March to RSVP**

Travel arrangements on the day: Parents  Walking  Bus

Town and Country Buses contact David Gilchrist 5572 2788

Portland & Heywood contact Michelle Ferey 5551 1203

Casterton contact Neale Guthrie 0419 518280

*Please turn over.....*