



**SQUARE ONE 2012
PERMISSION NOTE**

PLEASE COMPLETE BOTH SIDES

Name of child: Preferred name:

Date of Birth: Year in school: School attended:

Parent/Guardian name(s):

Address:

..... Postcode:

Home phone:

Child mobile: Parent/guardian mobile:

Child email: Parent/guardian email:

Alternate emergency contact (if parent/guardian unavailable):

Name: Relationship to child:

Contact phone number:

Please give details of a) any person/s not permitted to contact or collect your child while in the care of the above-named group and b) any Court order related to such:

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I consent to my child becoming a member of SQUARE ONE. I will encourage my child to attend and participate regularly and to cooperate with the leaders and other children.

I authorize the leader in charge of the above mentioned group where it is impracticable to communicate with me, to arrange for my child to receive such medical treatment as the leader may deem necessary at any time during the activities of SQUARE ONE. I further authorize the use of Ambulance if in the leader's judgment it is necessary. I accept responsibility for payment of all expenses associated with such treatment.

I appreciate that every care will be taken by the leaders of the above mentioned group and that the leaders and those connected with that group cannot be held responsible for personal injury, loss or theft of property affecting my child.

Signature of Parent/Guardian: Date:

Name:

PTO

Confidential Medical Report

The information below is request to assist in case of any illness or accident. This information will be held in confidence.

1. Please tick if your child suffers from any of the following:

- heart condition
- blackouts
- asthma
- sleepwalking
- migraines
- other (please specify):

2. Is your child presently taking medication? **YES/NO** If yes, please state the name of the medication, dosage, etc.:

3. Is your child allergic to:

- penicillin
- bee stings
- other (please specify degree of reaction):

4. Last tetanus immunization: / /

5. Medicare No: Medical/Hospital Fund:
Contribution No:

6. Name of family doctor: Ph.:

7. Can your child swim? **YES /NO** Distance in metres?

PLEASE LIST any physical or special needs (i.e. dietary requirements, food allergies etc.)

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I confirm that the particulars given on the accompanying confidential medical questionnaire are correct and accept responsibility for the declaration above.

I understand that photos and video of my child may be taken during the program and used in promotion of future events and give permission for these to be taken and used. I give permission for my personal details and information to be kept confidentially and used by SQUARE ONE or TURRAMURRA UNITING CHURCH.

Signed Parent /Guardian:..... Date:

PLEASE COMPLETE THIS FORM AND RETURN IT TO KATE MCLEAN ON YOUR FIRST TIME AT SQUARE ONE.