



# EDUCANG MEDICAL CONSENT FORM



This form is to be filled in by a Parent or Guardian of any student attending the off-campus activity, excursion or camp. The information contained herein is required by Medical Practitioners in the event of students requiring treatment.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Address: \_\_\_\_\_

Telephone Number: Home: \_\_\_\_\_

Mother's Work : \_\_\_\_\_ Mother's Mobile: \_\_\_\_\_

Father's Work: \_\_\_\_\_ Father's Mobile: \_\_\_\_\_

Name of Medical Insurance Fund: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

Has your child had a tetanus booster in the last 12 months? Yes/No

**Does your son/daughter suffer from any of the following:**  
(Please give full details including severity, medication, date of last attack, operation etc.)

- Heart Problems \_\_\_\_\_
- Respiratory Problems \_\_\_\_\_
- Asthma \_\_\_\_\_
- Other Respiratory Problems \_\_\_\_\_
- Allergies to: Food \_\_\_\_\_ Drugs \_\_\_\_\_  
Ointments \_\_\_\_\_ Other \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Epilepsy \_\_\_\_\_
- Blood Pressure \_\_\_\_\_ Bed Wetting \_\_\_\_\_
- Recent Illness/Operations \_\_\_\_\_
- Phobias \_\_\_\_\_
- Other \_\_\_\_\_

**MEDICATION**

Please give details of any medicines being taken by your child including dosage and frequency.

\_\_\_\_\_  
\_\_\_\_\_

**(All medication excluding asthma puffers must be handed to form teachers at the commencement of the camp. Regular medication procedures and expectations apply. All medication must be accompanied by a medication form and instructions signed by a medical practitioner.)**

I hereby authorize the Executive Principal of EDUCANG Ltd or his duly appointed representatives to obtain such medical attention as may be deemed necessary and I understand that I am responsible for the costs. I further authorize qualified medical practitioners to administer anaesthetic and blood transfusion if the necessity arises.

---

Parent/Guardian Signature

---

Date