Covenant Christian School
All knowledge through Christ

EMERGENCY & MEDICAL CONSENT FORM

Name of Student:_____ Home Class:_____

Address:_____

Mobile No: _____ Date of Birth:_____ Gender: ❒ Male ❒ Female

Emergency Contacts:

Name:_____ Relation to Student: _____

Phone: home:_____ work:_____ mobile:_____

Name:_____ Relation to Student: _____

Phone: home:_____ work:_____ mobile:_____

Medicare Number:_____ Ambulance Cover: ❒ Yes ❒ No

Private Medical Cover: ❒ Yes ❒ No Health Fund & No.:_____

Please answer the following medical questions regarding your son/daughter:

Is your son/daughter in good health? ❒ Yes ❒ No

Does your son/daughter suffer from any chronic illness or disability (eg Diabetes, Epilepsy, etc)?

❒ Yes ❒ No

If yes, please specify:_____

_____

Does your child suffer from any of the following?

❒ Sleepwalking ❒ Bedwetting Details:_____

Does your son/daughter suffer from Asthma? ❒ Yes ❒ No

If yes, please complete page 3.

Do you give permission for the following medications to be administered to your son/daughter if required?

Paracetamol ❒ Yes ❒ No Aspirin ❒ Yes ❒ No Ventolin ❒ Yes ❒ No

Claratyne ❒ Yes ❒ No Nurofen ❒ Yes ❒ No

Does your child require regular medication? ❒ Yes ❒ No

If yes, please specify (dosage, frequency, before/after meals etc): _____

_____

_____

Does the medication require refrigeration? ❒ Yes ❒ No

Has your son/daughter had the Diptheria Tetanus Toxoid Booster injection? ❒ Yes ❒ No

If yes, what year was the last booster given? _____

Has your son/daughter suffered from any acute illness in the last four months? ❒ Yes ❒ No

If yes, please specify: _____

_____

Has your child been treated by a doctor in the last four weeks? ❒ Yes ❒ No

If yes, please attach a medical certificate (if possible) outlining treatment, and stating that the participant is fit to attend camp.

Has your son/daughter had any major surgery (knee, back, heart, etc)? ❒ Yes ❒ No

If yes, please specify:_____

_____

Does your son/daughter have any allergies (insects, food, medication, etc)? ❒ Yes ❒ No

If yes, mild / moderate / severe *(please circle)*. Details:_____

_____

Does your son/daughter have any special dietary requirements? ❒ Yes ❒ No

If yes, please specify:_____

_____

Can your child tread water? ❒ Yes ❒ No Is your child a competent swimmer? ❒ Yes ❒ No

How far can your son/daughter swim? _____

Parent or Guardian Consent

In the event of any accident or illness and I am unable to be contacted, I authorise the obtaining of such medical assistance on my behalf that my son/daughter may require. I also agree to cover medical fees and/or cost of such assistance that may be incurred while my son/daughter is on the camp.

I acknowledge an inherent risk associated with camp and the activities involved, and hereby give permission for my son/daughter _____ to attend _____ on _____ .

Signature:_____ Date: _____
(Parent/Guardian)

Name: _____

School Camp Asthma Management Plan

Asthma FOUNDATION NEW SOUTH WALES

Usual Asthma Management Plan

Usual signs of student's asthma	**Worsening signs of student's asthma**	**What triggers the student's asthma?**
❒ Wheezing ❒ Tightness in chest ❒ Coughing ❒ Difficulty in breathing ❒ Difficulty in speaking ❒ Other (please describe) _____ _____ _____	Increased signs of: ❒ Wheezing ❒ Tightness in chest ❒ Coughing ❒ Difficulty in breathing ❒ Difficulty in speaking ❒ Other (please describe) _____ _____ _____	❒ Exercise ❒ Colds/Viruses ❒ Pollens ❒ Dust ❒ Food Which foods? _____ Other Triggers (please note) _____ _____

Does your child need assistance taking their medication? ❒ **Yes** ❒ **No**

Any other information that will assist with the asthma management of the student while on camp (eg peak flow, asthma action plan, night time asthma, recent attacks (attach additional information if necessary)

_____

_____

Medication requirements: (including preventers, symptom controllers or medication needed before exercise)		
Name of Medication	Method (eg puffer & spacer, turbuhaler)	When and how much?

❒ I give permission for standard Asthma first aid to be administered in the event of an asthma attack.

Parent's/Carer's Signature: _____ Date: _____

For further information about the **Asthma Friendly School Program** and asthma management, please contact The Asthma Foundation of NSW on (02) 9906 3233, Toll Free 1800 645 130, email afs@asthmansw.org.au or visit their website www.asthmansw.org.au**.**