

MEDICAL INFORMATION DETAILS

PARENT/GUARDIAN AGREEMENT & CONSENT (Not necessary if the student is over 18 years)

I,.....consent to my child taking part in this Structured Learning arrangement and I:

- agree that he or she will be subject to the direction and control of the trainer and/or nominated workplace supervisor(s);
- understand that all reasonable care for the health and safety of my child will be taken by the trainer and/or nominated workplace supervisor(s);
- understand that I will be notified as soon as possible in the event of illness of or accident to my child, but where it is impracticable to communicate with me I authorise the person in charge at the workplace of the employer to consent to my child receiving such medical and surgical treatment (including the administration of an anaesthetic) as may be deemed necessary by a legally qualified medical practitioner;
- expect my child to comply with all reasonable rules and requirements governing safety and behaviour;
- attach details of any known medical condition which may affect my child, and any medication or treatment which may be relevant.

Signature Parent or Guardian..... Date

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Privacy Advice

The information provided on this form is being obtained for the purpose of ascertaining relevant medical Information, requirements and other health care related needs about your child.

The information will be used by FS Learning administrators to assist planning, to support students, and to minimise risks when conducting structured learning activities.

Provision of this information is not required by law. However provision of the information will significantly assist FS Learning in planning suitable vocational educational activities.

This information will be stored securely. If you have any concerns about provision of this information, please contact FS Learning directly.

Student Name _____

Medicare Number - optional _____

Parent or caregiver contact details

Name: _____

Address: _____

Home phone: _____ Work phone: _____ Mobile phone: _____

Doctor contact details

Name: _____

Address: _____

Doctor's telephone: 1. _____ 2. _____

Emergency alternative contact/s details

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

List existing medical conditions or illnesses (include asthma, diabetes, epilepsy, allergies etc.). Outline treatment for each.

Outline special dietary needs including possible reaction to inappropriate diet.

Medication/s to be administered during the excursion. Include name of medication, instructions for administration, time of administration, and any possible reactions.

Signature of parent or caregiver: _____ Date _____