



# MOUNT RIVERVIEW PUBLIC SCHOOL

RUSDEN ROAD, MOUNT RIVERVIEW, NSW 2774

PHONE: (02) 4739 2180 (02) 4739 2063

EMAIL: [mtrivervie-p.school@det.nsw.edu.au](mailto:mtrivervie-p.school@det.nsw.edu.au)

## MEDICAL INFORMATION FORM FOR OVERNIGHT EXCURSION

|   |  |                          |  |
|---|--|--------------------------|--|
| Student's Name:   |  |                          |  |
| Parents' Names:   |  | Phone Numbers:           |  |
| Emergency Contact Name (other than parent):                         |  | Phone Numbers:           |  |
| Student's Doctor:   |  | Phone Number:            |  |
| Medicare Number:  |  | Card Reference Number:   |  |
| Medicare Expiry Date:   |  | Health Care Card Number: |  |
| Private Health Insurance Provider?                                  |  | Membership Number:       |  |
| Does Private Health Insurance include ambulance cover?    Yes    No |  |                          |  |

### PERSONAL HISTORY

Does your child suffer from .....

|                              |                              |                             |
|------------------------------|------------------------------|-----------------------------|
| Asthma                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| An allergic condition        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin Condition               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy, fits or black outs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Adverse reaction to drugs    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, please give details: |                              |                             |

Does your child suffer from any other chronic illness or disability?    **YES or NO**

If YES, please provide details.

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Has your child suffered any acute illness or injury during the past few weeks?    **YES or NO**

If YES, state the nature of the illness or injury.

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Is your child taking any form of medication at present? **YES or NO**

*If YES, please send in written advice in regards to what it was prescribed for, name of medication and instructions for administration.*

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Please outline any special dietary needs.

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|--|------------------------------|-----------------------------|
| Does your child wet the bed?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your child had the combined Diphtheria Tetanus Toxoid booster injection?           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your child been away from his/ her parents before?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your child allowed medication (Panadol or similar) for treatment of minor ailments? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your child suffer from travel sickness?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Is there any additional information we need to be aware of? **YES or NO**

*If YES, please state.*

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#### **Consent to Publish**

I give permission for photographs of my child to be taken at this event. I understand these photographs may then be used in, *but not limited to*, the local media and school publications such as the newsletter, website, school APP and presentation slideshows.

**In the event of any accident or illness, I authorise the obtaining on my behalf such medical assistance as my child may require.**

**I also undertake to pay medical fees and/or costs of medicine which may be incurred while my child is participating in this overnight excursion.**

\_\_\_\_\_  
Parent/Caregiver's Name

\_\_\_\_\_  
Parent/Caregiver's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date