Seaford
Secondary College

# MEDICAL/CONSENT FORM

Student's Name: …… Care Group: ……

Address: ……

…… Postcode: ……

Phone (Home): …… Mobile: ……

Medicare No: …… Emergency Contact: ……
(please include name of contact)

I consent to my child participating in:

……

I also authorise the teacher in charge to consent, where it is impractical to communicate with me, to my child receiving such medical or surgical treatment as may be deemed necessary (the cost to be borne by the parents).

**MEDICAL INFORMATION**

Please indicate if any medication is required.

| | | INFORMATION |
|---|---|---|
| Medication Required/Carried | YES/NO | |
| Heart Problems | YES/NO | |
| Respiratory Problems | YES/NO | |
| Allergies (e.g. Bee Stings/Hay Fever) | YES/NO | |
| Blood Pressure | YES/NO | |
| Phobias (e.g. Confined Spaces/Heights) | YES/NO | |
| Operations (Recent) | YES/NO | |
| Illness (Major/Recent) | YES/NO | |
| Epilepsy | YES/NO | |
| Diabetes | YES/NO | |
| Vision or Hearing Problems (e.g. Glasses, Hearing Aids) | YES/NO | |
| Asthma | YES/NO | |
| Other Relevant Conditions (e.g. ADHD, Dermatitis) | YES/NO | |
| Drug Reactions (e.g. Penicillin Allergy) | YES/NO | |

**ADDITIONAL INFORMATION:**

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Parent/Caregiver Name: ……

Signature: …… Date: ……./……./…….

Government of South Australia
Department for Education