Mount Colah Public School

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Telopea Street
Mount Colah
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MT COLAH PUBLIC SCHOOL

Years 3/4 – Vision Valley Camp - 2017
Medical Form

Name:_____

Address:_____

Phone:_____ Medicare No._____

Emergency Contact:_____ Phone No.: _____

Allergic to Bee Stings	Yes	☐	No	☐
Allergic to Penicillin	Yes	☐	No	☐
Immunised against Tetanus	Yes	☐	No	☐
Travel Sickness	Yes	☐	No	☐
Wets the bed	Yes	☐	No	☐

Any medical problems that should be known (especially allergies):

_____

_____

Current Medications (including travel sickness pills, asthma sprays):

_____

_____

Please Note
All medications (except for travel sickness pills and asthma sprays) to be clearly marked with all necessary directions and handed to the teacher in charge, with the letter of authority.

Additional Information (Include special dietary requirements for cultural, religious or medical reasons)

_____

_____

I give permission for my child to be taken to a doctor or hospital for medical treatment if deemed necessary by the supervising teacher.

Signature:_____ Date: _____
Parent/Guardian