# CO-CURRICULAR CONSENT FORM

**SPORT/ACTIVITY:** _____

| NAME OF STUDENT | | |
|---|---|---|
| | **(Preferred Given Name)** | **(Family Name)** |
| **SCHOOL** | **MARRYATVILLE HIGH SCHOOL** | |

As a Parent/Guardian of the above student, I give my consent for him/her to participate in the above listed activity. I agree to delegate my authority to the staff and/or coaches involved to ensure the safety, wellbeing and successful conduct of students.

I understand that this consent form is a contract of commitment by my student to attend all practices and matches throughout the season, and that should he/she be unable to do this, that a sound reason will be provided to the coach in advance. As a Parent/Guardian I am aware that my student needs to participate in accordance with the guidelines stipulated in the Marryatville High School Sports Policy, specifically the code of conduct.

In the event of an accident or illness and contact with me being impracticable or impossible, I authorise the staff/coach in charge to arrange whatever medical or surgical treatment a registered medical practitioner considers necessary. I will pay all medical and dental expenses incurred on behalf of my student.

I have also attached additional or updated health care information, including details of any additional health support he/she requires to undertake the above activities safely. I also consent to my student's doctor or medical specialist being contacted in an emergency.

The information given is accurate to the best of my knowledge.

**Signed** _____ **Date: / /**

**MEDICAL INFORMATION**

**Information contained in this section is necessary to ensure that the student's medical conditions are properly managed, however, no student with special needs will be excluded unless on medical advice.**

| DOES YOUR STUDENT HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? | MARK ☒ IN BOX | FURTHER INFORMATION OR SPECIAL INSTRUCTIONS. IF MEDICATION REQUIRED, SEND WITH STUDENT |
|---|---|---|
| **CONVULSIONS/SEIZURES (e**.g. Epilepsy) | ☐ Yes ☐ No | |
| **ASTHMA OR OTHER CHEST PROBLEMS** | ☐ Yes ☐ No | |
| **ALLERGIES** (e.g. Bee Sting) | ☐ Yes ☐ No | |
| **DIABETES** | ☐ Yes ☐ No | |
| **VISION or HEARING PROBLEMS** (e.g. Glasses or Hearing Aid) | ☐ Yes ☐ No | |
| **EAR DISORDER** (e.g. Drainage tubes) | ☐ Yes ☐ No | |
| D**ERMATITIS** (e.g. relevant skin conditions) | ☐ Yes ☐ No | |
| **OTHER RELEVANT CONDITIONS** (e.g. Attention Deficit Hyperactivity Disorder) | ☐ Yes ☐ No | |
| **MEDICATION / EMERGENCY MEDICATION** (e.g. any current medication) | ☐ Yes ☐ No | |

## CO-CURRICULAR

## EMERGENCY CONTACT INFORMATION

**This additional information will allow us to respond quickly in the event of a medical emergency.**

| | | | |
|---|---|---|---|
| **STUDENT CONTACT DETAILS** | | | |
| **STUDENT** | **Name:** | **(H)** | **(Mob)** |
| **CAREGIVER CONTACT DETAILS** | | | |
| **FIRST CAREGIVER** | **Name:** | **Relationship:** | |
| | **(H)** | **(W)** | **(Mob)** |
| **SECOND CAREGIVER** | **Name:** | **Relationship:** | |
| | **(H)** | **(W)** | **(Mob)** |
| **OTHER CONTACT** | **Name:** | **Relationship:** | **(Ph)** |
| **EMERGENCY CONTACT** | **Name:** | **Relationship:** | **(Ph)** |
| **OTHER DETAILS** | | | |
| **FAMILY DOCTOR** | **Name:** | **Address:** | **(Ph)** |
| **MEDICARE** | **Number:** | **Expiry:** | **Number on card:** |
| **PRIVATE HEALTH** | **Fund:** | **Number:** | |
| **AMBULANCE COVER** | **Details:** | | |
| **OTHER RELEVANT INFORMATION** | **Details:** | | |

**If any of your information changes throughout the year you MUST inform your student's coach, as well as Student Services on 8304 8426.**