**Medical Information Form for Overnight Excursions – Page 1**

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Class:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Telephone:</td>
<td>Contact No.</td>
</tr>
<tr>
<td></td>
<td>(During Day):</td>
</tr>
<tr>
<td>Child's Doctor:</td>
<td>Telephone</td>
</tr>
<tr>
<td></td>
<td>(Doctor):</td>
</tr>
<tr>
<td>Private Health Insurance Fund:</td>
<td>Member No.</td>
</tr>
<tr>
<td>Medicare Number:</td>
<td></td>
</tr>
</tbody>
</table>

**Does your private health insurance include Ambulance Cover?**
- [ ] YES  [ ] NO

**Do you have Ambulance Cover?**
- [ ] YES  [ ] NO

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**PERSONAL HISTORY – Please answer the following questions:**

1. **Is he/she in good health?**
   - [ ] YES  [ ] NO

2. **Does he/she suffer from any of the following:**
   - a. Asthma or any allergic conditions?
     - [ ] YES  [ ] NO
   - b. Skin conditions?
     - [ ] YES  [ ] NO
   - c. Epilepsy, fits or blackouts?
     - [ ] YES  [ ] NO
   - d. Diabetes?
     - [ ] YES  [ ] NO
   - e. Adverse reactions to drugs?
     - [ ] YES  [ ] NO

If you have answered YES to any of the questions above, please give details:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

3. **Does your child suffer from any chronic illness or disability?**
   - [ ] YES  [ ] NO

If you have answered YES to question 3, please give details:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

4. **Has he/she suffered from any acute illness or any injury during the past four weeks?**
   - [ ] YES  [ ] NO

If you have answered YES to question 4, please give details:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

5. **Is he/she taking any form of medication at present?**
   - [ ] YES  [ ] NO

If you have answered YES to question 5, please give details:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

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Please Turn Over ➔
6. Does he/she wet the bed?  
   □ YES  □ NO

7. Has he/she had the combined Diphtheria/Tetanus/Toxoid booster injection?  
   □ YES  □ NO

8. Has he/she been away from parents before?  
   □ YES  □ NO

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**FOOD ALLERGIES/SPECIAL DIETARY NEEDS/TRAVEL SICKNESS**

9. Does your child have any allergies to any particular types of foods/products?  
   □ YES  □ NO

   If you answered YES to question 9, please give details:
   
   __________________________________________________
   __________________________________________________
   __________________________________________________
   __________________________________________________
   __________________________________________________
   __________________________________________________

10. Does your child have any special dietary needs?  
    □ YES  □ NO

   If you answered YES to question 10, please give details:
   
   __________________________________________________
   __________________________________________________
   __________________________________________________
   __________________________________________________
   __________________________________________________
   __________________________________________________

11. Does your child suffer from Travel Sickness?  
    □ YES  □ NO

   If you answered YES to question 11, please provide details of medication: ________________________________

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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 medications which may be incurred while my child is participating in this overnight excursion.

Signed: ___________________________  Date: ___________________________