# Donnybrook Community Church
# Children's Indemnity & Permission Form

| | |
|---|---|
| **Program/Group Name:** | |

| | | | |
|---|---|---|---|
| Child's Full Name: | | | |
| Date of Birth: | | Gender: | |

| | | | |
|---|---|---|---|
| Emergency contact: | | Relationship: | |
| Mobile Phone: | | Home Ph: | |

Please give details of a) any person/s not permitted to contact or collect your child/ren while in the care of the above named group and b) any Court order related to such:

| |
|---|
| |
| |
| |

I consent to my child becoming a member of the above program. I will encourage my child to attend and participate regularly and to cooperate with the leaders and other children.

I authorise the leader in charge of the above-mentioned group to arrange for my child to receive such first aid, medical or surgical treatment as the leader may deem necessary at any time during the activities. I further authorise the use of Ambulance and/or anaesthetic by a qualified medical practitioner if in his/her judgment it is necessary. I accept responsibility for payment of all expenses associated with such treatment.

I agree to indemnify and hold harmless the Donnybrook Community Church, the church, and any individual staff or voluntary leaders against all claims arising out of any injury to the child, and the relevant activity being undertaken unless such injury results from a failure in the duty of care of the Donnybrook Community Church, the church, or any individual staff or voluntary leader.

There may be occasions when it is necessary to transport children or to walk to nearby facilities. This will not occur without seeking your permission, except in the case of an emergency evacuation.

**SIGNATURE OF PARENT/GUARDIAN:**

**Name:** _____ **Signature:** _____ **Date:** _____

**CONFIDENTIAL MEDICAL REPORT**

*The information below is requested to assist in case of any illness or accident, and will be held in confidence. This information may be passed on to medical care providers in the event of an emergency. This information will be securely destroyed once it is no longer required or is replaced. Please note: some medical conditions may require us to request a Medical Action Plan.*

**a) Please tick if you or your child suffers from any of the following:**

[ ] Heart Condition [ ] Sleepwalking [ ] Blackouts [ ] Migraines

[ ] Penicillin Allergy [ ] Bee Sting Allergy [ ] Nuts Allergy [ ] Asthma

[ ] Anaphylaxis (please specify allergen and attach Action Plan if applicable) _____

[ ] Other *(please specify)*_____

**b) Does your child have any allergies to any foods/medications/other?**

If you already selected an allergy in a), you don't need to list this again

| |
|---|
| |
| |

**c) Is your child presently taking medication? If yes, please state the name of the medication, dosage, etc:**

| |
|---|
| |
| |

**d) Approximate date of last tetanus immunisation:** ____ / ____ / _____

**e) Medicare No:** __ __ __ __ __ __ __ __ __ __ __ **Valid to:** __ / __ __ __ __

**f) Health Insurance and/or Ambulance Cover Provider:** _____

**Member No:** _____

**g) Name of family Doctor/Clinic:** _____ **Ph:** _____

**h) Name of Dentist:** _____ **Ph:** _____

**i) Please list any physical or special needs: (e.g. Dietary requirements not listed under b) above)**

| |
|---|
| |
| |
| |
| |

**SIGNATURE OF PARENT/GUARDIAN:**

**Name:** _____ **Signature:** _____ **Date:** _____