



Children's Program

Childs Name: \_\_\_\_\_

Home Street address .....

Suburb ..... State ..... P Code .....

Date of Birth / / .....

Parent/Guardian name \_\_\_\_\_

Mobile no .....

Drop off time: Pick up time:

If you are not collecting your child, they will be picked up by: \_\_\_\_\_ (Name)

Will you be at the main conference for the whole time that your child will be at the children's program? YES / NO

MEDICAL INFORMATION

The following information is supplied in confidence to assist the team. If the answer to any question is yes, please supply full details...

- Heart problem ..... Yes No
Asthma ..... Yes No
Phobia ..... Yes No
Operations ..... Yes No
ADD - Attention Deficit Disorder ..... Yes No
ADHD - Attention Deficit Hyperactivity Disorder ..... Yes No
Recent illness ..... Yes No
Migraines ..... Yes No
Blackouts ..... Yes No
Fits, Epilepsy, etc. .... Yes No
Special diet ..... Yes No
Any restrictions on activities ..... Yes No
Disability (physical/intellectual/emotional) ..... Yes No
Known behavioural problems ..... Yes No
Is medication required? (attach details) ..... Yes No
Drug reactions (eg. Penicillin allergy) ..... Yes No
Allergies (i.e. food, bee stings) ..... Yes No
Approximate date of last tetanus booster / /

HEALTH DETAILS (in case you cannot be contacted)

Childs Medicare Number ..... Expiry date / /

PHOTOS/ADVERTISING

I do not wish photos or video of my child to appear in promotional material

Kind Regards, Lorelle Gibbins - 0416 008 151