



PERMISSION FORM
 Ministry and Mission with Children
 Synod of New South Wales
 Uniting Church in Australia



For the congregation

Name of program/s (if applicable)

Name of child: _____ Preferred Name: _____

Date of Birth: / / Family Name/s: _____

Address: _____

Phone: _____ Mobile: _____ E-mail: _____

Alternate emergency contacts:

1. Name : _____ Relationship to child: _____ Phone: _____

2. Name : _____ Relationship to child: _____ Phone: _____

Please give details of a) any person/s not permitted to contact or collect your children 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 _____

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 where it is impracticable to communicate with me, to arrange for my child to receive such medical treatment as the leader may deem necessary at any time during the activities of _____. I further authorise the use of Ambulance if in the leader's judgment it is necessary. I accept responsibility for payment of all expenses associated with such treatment.

I appreciate that every care will be taken by the leaders of the above mentioned group and that the leaders and those connected with that group cannot be held responsible for personal injury, loss or theft of property affecting my child.

There may be occasions when it is necessary to transport children or to walk to nearby facilities. I DO / DO NOT give permission for my child (as above named) to participate in activities outside of the normal meeting complex.

I DO / DO NOT give permission for my child to be transported in private cars arranged by the leaders of the above named group.

Signature of Parent/Guardian:

_____ Name: _____

_____ Name: _____ Date //

CONFIDENTIAL MEDICAL REPORT

The information below is requested to assist in case of any illness or accident. This information will be held in confidence.

- 1. Please tick if your child suffers from any of the following:
 - Heart condition;
 - Blackouts;
 - Asthma;
 - Sleepwalking;
 - Bedwetting;
 - Migraines;
 - Other (please specify): _____

- 2. Is your child presently taking medication? Yes No *If yes, please state the name of the medication, dosage, etc* _____

- 3. Is your child allergic to:
 - Penicillin;
 - Bee stings;
 - Nuts;
 - Other drugs (please specify): _____

- 4. Last tetanus immunisation: / /

- 5. Medicare No: _____ Medical/Hospital Fund: _____
Contribution No: _____

- 6. Name of family doctor: _____ Ph: _____

- 7. Name of Dentist: _____ Ph: _____

- 8. Please list any physical or special needs: (e.g. dietary requirements, food allergies)

Please complete and return to by / /

The leadership team, of the aforementioned event, will treat the information contained confidentially. This information may be shared with a third party when it concerns medical health or care of the individuals listed. If you wish to access this information or have any queries in relation to the manner in which we handle your personal information, please do not hesitate to contact us.