**PART C: CONFIDENTIAL MEDICAL CONDITIONS FORM**

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| --- | --- |
| Child’s full name: (surname last and in CAPITALS) |  |
| Child’s date of birth  |  |
| Child’s address  |  |
| Date/s of activity  |  |
| Child’s Medicare Number  |  |
| Do you have Private Health Insurance?  |  |
| If yes, name of fund and policy number  |  |
| Is the child covered by an Ambulance subscription?  |  |
| If yes, subscription number  |  |
| Family doctor’s name  |  |
| Family doctor’s address  |  |
| Family doctor’s telephone number |  |

Does your child have any medical conditions which may require special attention? If so please provide details.

Is your child currently taking any medication? If so please provide details including name of medication, dosage, when and how it is to be taken.

Does your child have any allergies? If so please provide details.

Does your child have any special dietary needs? If so please provide details.

Is there any other information we should know about your child’s needs?

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Signature of Parent/Guardian Print name (surname last and in CAPITALS)

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Relationship to child Date