

THOMASTOWN PRIMARY SCHOOL 631
Student Emergency Contact Details

Please Print **CLEARLY**

Child's full name	
Date of birth	Country of birth
Home address	
Home telephone	
Does your child suffer from ASTHMA?	Please circle - Mild/Severe
	If yes for ASTHMA - we need an asthma plan from your doctor (signed and stamped)
Any IMPORTANT Medical details or Custody Restrictions?	
Language spoken at home	
Name/address/telephone of preferred Doctor in this area	
Parents	
Father's name	
Address	
Place/address of work	
Work telephone and/or mobile	
Mother's name	
Address	
Place/address of work	
Work telephone and/or mobile	
OTHER Contacts	
To be used if your child becomes ill	
<i>Name/telephone</i>	
<i>Name/telephone</i>	

In the event of illness or injury to my child whilst at school, on an excursion, or travelling to or from school; I authorize the Principal or a senior staff member in charge of my child, where it is impracticable to communicate with me, to consent to emergency medical or dental arrangements on my behalf as are deemed necessary by a qualified medical practitioner. Such consent includes anaesthetics, blood transfusions and surgical operations.

_____ **Parent Signature**

Thank you for taking the time to complete this student form
The details are confidential but are required to enable staff to properly care for your child whilst at our school