This form or a copy must be taken on the event.

Health and Consent Form for Camps and Trips Outside of the Hamilton City Boundary

Details on this form will remain confidential to school staff and other adults associated with supervising activities on the event.

Akomanga:	**Teacher:**
Event: Hamilton Zoo Trip	
Location: Hamilton Zoo, 183 Brymer Road, Rotokauri, Baverstock	
Date: Wednesday April 9th 2025	

NAME OF CHILD: _____ **Akomanga:** _____

Name of parent / caregiver:		
Address:		
Phone (day)	**(evening)**	**(cell phone)**

EMERGENCY CONTACT DETAILS		
Name:		
Relationship to child:		
Phone (day)	**(evening)**	**(cell phone)**

HEALTH and MEDICAL INFORMATION

Please tick if your child has any of the following:

☐ migraine ☐ diabetes ☐ hayfever	☐ epilepsy ☐ travel sickness ☐ other (please specify)	☐ asthma ☐ sinus problems
Treatment required?		

Please tick if your child is allergic to any of the following:

☐ prescription medicine ☐ other allergies (please specify)	☐ food	☐ insect bites/stings
Treatment required?		

Is there any other information the staff should know to ensure the physical & emotional safety of your child?

If YES, please give details:

Does your child currently take any medication?	☐ **Yes**	☐ **No**

If YES, please state:

- Ailment/s:
- Name of medication:
- Dosages and times to be taken:
- Other treatment:

PTO

Health and Medical Information continued:

When was your child's last tetanus injection? _____

May your child be given pamol/paracetamol if necessary? _____

To the best of your knowledge, has your child been in contact with any contagious or infectious disease in the last four weeks?

☐ Yes If YES, please give brief details

☐ No

CONSENT INFORMATION

Please tick boxes and sign below:

☐ I approve of my child taking part in this event, and have read the information sheet.

☐ In the event of an accident or illness, I agree to my child receiving any emergency medical, dental or surgical treatment as, in the opinion of a staff member, assisting parent or a medical professional, may be required.

☐ Any medical costs not covered by ACC or a community service card will be paid by me.

☐ I agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this.
I will ensure that prescribed medication is clearly labelled, securely fastened and given to the teacher with instructions on its administration.

☐ I understand and agree that the designated adult will make their best effort to administer the medication as directed and if they are inadvertently unable to, then I will take no action against them.

☐ If at some time in the future it is discovered that the medication has side effects, I will not take any action against the school administering the medication.

Signed: _____ Date: _____

Name: _____