TUGGERAH PUBLIC SCHOOL
EMERGENCY CONTACT FORM

To ensure that pupil information is accurately maintained the school asks the co-operation of parents in completing this emergency record ANNUALLY.

Please note that the school pays an annual ambulance subscription to cover all pupils while they are at school
PLEASE NOTIFY THE SCHOOL IMMEDIATELY WHEN CHANGES OCCUR TO THIS INFORMATION

Is the student of Aboriginal or Torres Strait Islander origin? Yes / No

Student Name: _____ **DOB:** _____ **Class:** _____

Student Name: _____ **DOB:** _____ **Class:** _____

Student Name: _____ **DOB:** _____ **Class:** _____

HOME ADDRESS: _____

Home Phone Number:_____

Parent/Carer Name: _____ **Business No:** _____ **Mobile No:** _____

Parent/Carer Name: _____ **Business No:** _____ **Mobile No:** _____

1. **Emergency Contact Person:** _____ **Phone No.** _____
   Relationship to child: _____ (eg relative, friend or neighbour)
2. **Emergency Contact Person:** _____ **Phone No.** _____
   Relationship to child: _____ (eg relative, friend or neighbour)
   Doctors Name: _____ **Phone No.** _____

ARE THERE ANY COURT ORDERS OR CUSTODY ISSUES IN RELATION TO YOUR CHILDREN?
◉ YES / NO ○
IF "YES" PLEASE PROVIDE DETAILS TO THE SCHOOL OFFICE.

MEDICAL

1. **DO ANY OF THE ABOVE CHILDREN SUFFER FROM ASTHMA?** ○ **Yes / No** ○
2. **ARE ANY OF THE ABOVE CHILDREN ON ANY LONG TERM MEDICATION?** ○ **Yes / No** ○
3. **DO ANY OF THE ABOVE CHILDREN SUFFER FROM ALLERGIES?** ○ **Yes / No** ○
4. **DO ANY OF THE ABOVE CHILDREN SUFFER FROM ANY SERIOUS MEDICAL PROBLEMS/DISABILITIES THAT THE TEACHER SHOULD BE AWARE OF?** ○ **Yes / No** ○

IT IS IMPORTANT THAT IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS THAT YOU COMPLETE THE BACK OF THIS FORM AND RETURN TO OFFICE WITH CURRENT STUDENT HEALTH PLAN COMPLETED BY HEALTH CARE PROFESSIONAL.

DO ANY OF THE CHILDREN SUFFER FROM ASTHMA?

Child's Name: _____ Mild: ____ Moderate: ____ Severe: _____

Child's Name: _____ Mild: ____ Moderate: ____ Severe: _____

Child's Name: _____ Mild: ____ Moderate: ____ Severe: _____

DO ANY OF THE CHILDREN SUFFER FROM ALLERGIES?

Child's Name: _____ Mild: ____ Moderate: ____ Severe: _____

Allergy and Symptons: _____

Child's Name: _____ Mild: ____ Moderate: ____ Severe: _____

Allergy and Symptons: _____

Child's Name: _____ Mild: ____ Moderate: ____ Severe: _____

Allergy and Symptons: _____

SERIOUS MEDICAL PROBLEMS/DISABILITIES:

Child's Name: _____

Details: _____

Child's Name: _____

Details: _____

If your child has a serious medical condition, have you completed a Student Health Plan? Yes/No

ARE ANY OF THE CHILDREN ON LONG TERM MEDICATION

Child's Name: _____ Medication & Details:_____

_____

Child's Name: _____ Medication & Details: _____

_____

EMAIL ADDRESS : _____

(Please print clearly and note that permission to publish will be taken from the enrolment form)

PERMISSION TO WATCH PG MOVIES: ◉ **YES / NO** ◯

_____

SIGNED: ..... **DATE: .....**

Privacy Statement: **The personal information provided on this form will be used by the Department of Education and Communities for general student administration and communication and other matters relating to the education and welfare of the student. This information will be stored securely. You may access or correct any personal information provided by contacting the school.**