SUTTON PARK SCHOOL
89 Vine Street, Mangere East, Auckland 2025
Telephone (09) 276 4560

Principal: Fata Vaitimu Togi Lemanu

YEARS 7/8 CAMP ADAIR - 2027

PERMISSION/MEDICAL/DIETARY - INFORMATION FORM

NAME _____ (child) Year _____ Room_____

Dear Parents / Caregivers,

To ensure the proper care of your child while he/she is on the trip, it is very important that you fill out the form below and return it to school as soon as possible.

ALLERGIES:

Does your child have any food allergies?

NO ☐

YES ☐

If **YES** please state what these are:

_____

_____

_____

Does your child have any medical allergies?

NO ☐

YES ☐

If **YES** please state what these are:

_____

_____

What medicine does your child take for their allergies?

_____

DIETARY REQUIREMENTS:

Does your child have any dietary requirements?

NO ☐

YES ☐

If **YES** please state what these are:

_____

_____

REGULAR MEDICATION:
Does your child take any regular medication?

NO ☐
YES ☐

If YES please state what it is: _____

What is the medication for? _____

How often must it be taken? _____

ASTHMA: Does your child have asthma?

NO ☐
YES ☐

Medication:_____Dose:_____

OTHER MEDICAL CONDITIONS:
Does your child have any other medication conditions that we should know about?

If **YES,** please state what it is.

SWIMMING

CAN YOUR CHILD SWIM? _____

IF YOU HAVE ANSWERED **YES**, PLEASE RATE THEIR LEVEL _____

NS – Non swimmer
W – Weak
S – Strong
A - Average

Are there any other issues or concerns we may need to know about your child? Please list below or come in and talk to us!

EMERGENCY CONTACT DETAILS #1: _____

NAME: _____

RELATIONSHIP TO PARTICIPANT: _____

MOBILE NUMBER: _____

HOME NUMBER: _____

EMERGENCY CONTACT DETAILS #2: _____

NAME: _____

RELATIONSHIP TO PARTICIPANT: _____

MOBILE NUMBER: _____

HOME NUMBER: _____

Permission/medical assistance consent: Please TICK if….

☐ I approve for my child to have photos taken by the school and placed on the school website and Facebook page.

☐ I give permission for a staff member to administer first aid medication and seek medical attention for my child if required.

☐ I agree to provide any medication in a clearly labelled container with my child's name and dosage instructions.

Parent / Caregiver Signature: _____Date: _____

Phone number _____

Home address:

E-mail address:

Kind regards,
TOM KATAFONO
Sutton Park School (09 276 4560)