

Baptist Union of Victoria

## Children's Indemnity & Permission Form

Church/Group:

.....

### Child's details

Name: .....

Date of birth: ...../...../.....

Address: .....

.....

Phone: ..... (H) Email: .....

Alternate emergency contact:

Name: ..... Relationship to child: .....

Phone: .....(H) .....(w) .....(M)

Please give details of a) any person/s not permitted to contact or collect your child/ren while in the care of the above named group and b) any Court order related to such:

.....

I consent to my child becoming a member of (name of group) .....

I will encourage my child to attend and participate regularly and to cooperate with the leaders and other children.

I authorize the leader in charge of the above mentioned group to arrange for my child to receive such first aid, medical or surgical treatment as the leader may deem necessary at any time during the activities of ..... I further authorize the use of Ambulance and/or anaesthetic by a qualified medical practitioner if in his/her judgment it is necessary. I accept responsibility for payment of all expenses associated with such treatment.

I agree to indemnify and hold harmless the Baptist Union of Victoria and the ..... Baptist Church against all claims, demands, suits and liability of whatever nature and howsoever arising out of the injury to the child, and the relevant activity being undertaken.

There may be occasions when it is necessary to transport children or to walk to nearby facilities.

I DO/DO NOT give permission for my child (as above named) to participate in activities outside of the normal meeting complex.

I DO/DO NOT give permission for my child to be transported in private cars arranged by the leaders of the above named group.

**SIGNATURE OF PARENT/GUARDIAN:** .....

Name: .....

Date: ...../...../.....

**CONFIDENTIAL MEDICAL REPORT**

*The information below is requested to assist in case of any illness or accident, and will be held in confidence.*

a) Please tick if your child suffers from any of the following:

- heart condition                       sleepwalking
- blackouts                       migraines
- asthma                                       travel sickness
- other (*please specify*) .....

b) Are you/your child presently taking medication? If yes, please state the name of the medication, dosage, etc. ....  
.....

c) Please tick if you/your child is allergic to any of the following:

- Penicillin                       Bee Stings
- other drugs (*please specify*) .....

d) Last tetanus immunization: .....

e) Medicare No: .....

Medical/Hospital Fund: .....

Contribution No: .....

f) Name of family Doctor: ..... Phone: .....

g) Name of Dentist: ..... Phone: .....

**Please list any physical or special needs: (eg. Dietary requirements, food allergies)**

.....

Please complete and return to: .....

by ...../...../.....