Consent for Medical Treatment

Please note: Consent for Medical Treatment is required to be completed as a member of Australian Performing Arts Network and a Student of APAN Academy. **(Please Print Very Clearly)**

Student Full Name: _____**Student Age:**_____**DOB:** ___/___/____
Male / Female

Parent Guardian Name: _____

Address: _____

City: _____State: _____Area Code_____

Parent 1 Phone: _____Parent 1 Mobile Phone: _____Father /Mother/Guardian

Parent 2 Phone _____Parent 2 Mobile Phone _____Father Guardian

Other Emergency Contact
Relative/ Guardian: Name_____ Phone _____ Mobile _____

Name of health insurer (HBF/ or other Other)_____ Insurance Company Ph: _____

Medicare Card Number _____and personal ID Number on card_____

Family Physician if known: _____Phone:_____

Paediatrician if known: _____Phone: _____

Student's allergies to the following medications:
_____

Student's allergies, if any:

_____

Date of Student's last tetanus booster if known:

_____

Medications student is **currently taking** or has taken in the last **6 months**:

_____

AS THE PARENT, AGENCY REPRESENATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO AUSTRALIAN PERFORMING ARTS NETWORK AND THEIR MEDICAL REPRESENTIVE TO PROVIDE THE ABOVE NAMED STUDENT – ALL FIRST AID, Authorise EMERGENCY DENTAL OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN OR DENTIST FOR STUDENT NAME:_____.

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDENT.

We / I have read this form, and certify that we / I understand its content and acknowledge consent for medical treatment.

Signature: _____Date:_____

Print Name _____
[Father, Mother, Legal Guardian]

******* STUDENTS WITH ASTHMA, ALLERGIES OR POTENTIAL EMERGENCY CONDITIONS MUST ALSO ATTACH AN EMERGENCY PLAN OF TREATMENT ISSUED BY THEIR GP OR SPECIALIST *******