

Please return the permission note and payment details to your child's teacher or Reception by Monday 2<sup>nd</sup> Sep

## Fresh Foods Discovery Tour

### CONSENT FORM

I give permission for my child \_\_\_\_\_ to attend the excursion to Tuggeranong Woolworths for the Fresh Foods Discovery Tour.

*Teachers may take whatever disciplinary action they deem necessary within the school's Student Management policy to ensure the safety, well-being and successful conduct of the students as a group or individually in the above mentioned activity. The teacher in charge is authorised to return the student home at the expense of the parent/guardian if it is considered that circumstances warrant such action.*

*Staff accompanying students on excursions will take all reasonable care while the students are in their charge to protect them from injury and to control and supervise their behaviour and activities.*

*Parents should be aware that staff members are not responsible for injuries or damage to property, which may occur on an excursion where, in all circumstances, staff have not been negligent. Parents should warn children of the risk to themselves, to others and to property, of impulsive, wilful or disobedient behaviour.*

*I authorise the teachers to obtain medical assistance which they deem necessary should an accident occur, and agree to pay all medical expenses incurred on behalf of the above student.*

*I further authorise qualified practitioners to administer anaesthetic and blood transfusion should the need arise.*

*I have read the attached information regarding this excursion and understand what it contains.*

Full name of Parent/Guardian (please print) \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_

#### Contact Numbers:

(a) Name: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

(b) Name: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

(c) Name: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Child has a medical condition: Yes / No (please circle)

Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor: \_\_\_\_\_

Medicare No: \_\_\_\_\_