



## Health Care Form

<b>Name:</b>	
<b>DOB:</b>	
<b>Gender:</b>	

Medical Details			
<b>Medical Practice:</b>			
<b>Doctor:</b>		<b>Ph:</b>	
<b>Dental Practice:</b>		<b>Ph:</b>	
<p>I give permission for WCYS to seek medical and/or dental attention for my child as required:</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>Do you have ambulance insurance?</b></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>NOTE: If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance.</i></p> <p><b>List any essential information that could affect your child in an emergency e.g. allergy to penicillin:</b></p> <hr/> <hr/>			
<b>Medicare Number:</b>	<b>Health Care Card:</b>		
	<b>Expiry:</b>		