MERCY COLLEGE MACKAY

PO Box 5646 • MACKAY MAIL CENTRE QLD 4741
Ph 4969 4199 • Fax 4969 4189
email - office@mercymackay.qld.edu.au

1 April 2019

Parent / Guardian:

Your child has been selected in the Mercy Cheer Squad to compete at the Winter Warm Up Competition in Townsville on the Saturday 1 and Sunday 2 June at the Townsville Basketball Stadium.

The cost of the trip is $150 which includes accommodation, travel expenses, breakfast, snacks and dinners; they will require money to purchase lunch on both the Saturday and Sunday. Accommodation will be at the Cedar Lodge Motel.

We will depart the College on Saturday morning very early and will return to the College on Sunday Evening. Times will be confirmed once the Program has been finalised and released.

A letter with the performance details and packing list will be forwarded to you once final arrangements have been confirmed.

For your child to participate, please complete the attached forms and return them with payment to the Finance Office by Friday 4 May in an envelope clearly marked with your child's name and Homeroom and the words 'Mercy Cheer Comp'.

If you require any further information please do not hesitate to contact me on 4969 4199 or via email cassandra_gillespie@mercymackay.qld.edu.au

Thank you for allowing your child to be a part of this wonderful event for the College.

Regards

Mrs Natalie Porter
Cheer Coordinator

Mr Jim Ford
Principal

✂----------

MERCY COLLEGE MACKAY
2019 Townsville Cheer Competition

Please complete and return to the Finance Office by Friday 04/05/2019 - GIL

I _____ give permission for _____

Homeroom _____ to attend the Winter Warm Up Competition in Townsville from 1 – 2 June.

☐ $150 enclosed ☐ Completed medical form enclosed

_____ _____
Parent/Guardian Signature *Date*

MERCY COLLEGE MACKAY

PERMISSION / MEDICAL FORM

Winter Warm Up Competition - Townsville
1/2 June 2019

Name of Student: ……

Student Mobile Number:……

Parents/Guardians

Please complete and return this Permission/Medical form which is intended to provide the teacher/supervisor with sufficient information to ensure your child's well-being and which, in the event of an accident or injury, can be passed on to appropriate medical authorities for any necessary emergency assistance.

PERMISSION DETAILS

a) I hereby give permission for my child to participate in the activity as detailed in the information provided to me. I am aware of the nature of the activity and agree to delegate my authority to the staff and instructors involved.

b) I consent to the teacher seeking such medical advice on behalf of my child as the teacher sees fit in the event of an accident or sudden illness when the teacher is not able to first contact me. If in such an emergency it is in the opinion of an attending medical or dental practitioner that my child requires medical or dental attention or treatment (including but not limited to the administration of anaesthetic, blood transfusion or the performance of any surgical operation), I consent to such medical or dental practitioner giving such attention or treatment.

c) I accept that the teachers and instructors will take appropriate disciplinary action necessary to ensure the safety, well-being and successful conduct of the students who participate in the activities associated with the excursion/educational trip.

PARENT CONTACT INFORMATION

Please provide information which would assist the teacher to make speedy contact with you in the event of an accident or injury requiring such contact.

NAME OF PARENT/GUARDIAN: ……

ADDRESS:……

HOME PHONE: ……**WORK PHONE:** ……**MOB:** ……

ALTERNATIVE CONTACT NAME: ……

HOME PHONE: ……**WORK PHONE:** …… ……**MOB:** ……

MEDICARE NUMBER: ……

SIGNED: …… **DATE:** ……

PARENT/GUARDIAN

Please turn over to complete medical details

MEDICAL INFORMATION

Strike out whichever of the following statements which does not apply to your child:

I certify that my child does not, to my knowledge, suffer from any illness or disability which might interfere with or inhibit any medical or dental attention or treatment.
OR
I give notice that my child suffers from the following illness or disability and/or takes medication which might interfere with or inhibit any medical or dental attention or treatment, but certify that to my knowledge, my child does not suffer from any other illnesses or disabilities or take medication which might interfere with or inhibit any medical or dental attention or treatment.

DETAILS:
……

……

……

Is your child on any prescribed medication(s) which would need to be continued during the excursion/educational trip? **YES [ ] NO [ ]**
(If yes please complete the Medication Whilst on School Excursion form and place in clear clipseal bag with chemist labelled medication and hand to teacher on morning of excursion)

(If Yes) DETAILS:
……

……

……

Does your child have any allergies (eg insect bites, food)? **YES [ ] NO [ ]**

(If Yes) DETAILS:
……

……

……

Is there any information you would like to give which, in your view, may affect your child's participation in the excursion? **YES [ ] NO [ ]**

DETAILS:
……

……

……

……

MERCY COLLEGE MACKAY

Penn Street MACKAY QLD 4740
Phone 07 4969 4199 Fax 07 4969 4189
Email: office@mercymackay.qld.edu.au

MEDICATION WHILST ON SCHOOL EXCURSION

At times it is necessary for students, under doctor's instruction, to take medication during school hours/school excursion. We are aware of this need and are willing to assist you in this situation. However, for the safety of the child, it is of utmost importance that the following form be completed in full. Please note that the medication must have a Chemist's label on it, clearly marked with the child's name and required dosage. Non-prescription medication such as Panadol or Nurofen must also have a chemist's label on it, marked with the child's name and required dosage. All medication will be administered by a member of staff.

Please place this form, along with medication in a zip-lock bag that is clearly marked with your child's name & Homeroom. Your child is to hand the zip-lock bag to **Miss Gillespie** on the morning, prior to leaving.

NON LABELLED MEDICATION WILL NOT BE ADMINISTERED

Thank you for your co-operation.

Mr Jim Ford
Principal

PARENTS/GUARDIANS NAME_____

CHILD'S NAME_____HOMEROOM_____

Phone number of Parent/Guardian to be contacted (if necessary) _____

Alternative phone number(s)_____

DOCTOR'S NAME _____PHONE NO_____

NAME OF MEDICATION _____

PERIOD OF MEDICATION _____

DOSAGE _____

Time of day medication is to be administered AM_____PM_____

Reason / Purpose for Medication _____

_____

(PLEASE NOTE: Medication must be clearly labelled with child's name, dosage and instructions for dispensing)

_____ _____
(Parent/Guardian Signature) (Date)