Northern Region School Sport
Representative Trials
Parent Consent Form / Medical Details

As parent/guardian of ____

I give my consent for him/her to participate in:

Sport: ________________________________ Date: ______________

Venue: ________________________________ Time: ______________

Transport: ______________________________ Cost: ______________

- I give permission for my son/daughter to attend representative trials for the sport stated above.
- I am aware that they must be available for NQ selection and the costs involved if they are selected.
- I agree to delegate my authority to the teachers and coach involved.
- The teachers may take whatever disciplinary action they deem necessary to ensure the safety, well-being and appropriate conduct of the students as a group or individually.
- I also authorise qualified practitioners to administer anaesthetic if such an eventuality arises.
- Unless otherwise organised, I understand that my son/daughter is responsible for their own transport to the trials.
- Any trial cost payable to the school prior to departure.
- A Project Consent Form permitting publication of name, image and school has been received by the student's school. *(Strike out if not applicable).*

Signed: ____________________________________ Date: ____________
(Parent/Guardian)

Signed: ____________________________________ Date: ____________
(Principal/Sports Coordinator)

Student Medical Information

Is there any medical or psychological reason to prevent your child from participating in Northern Sporting Trials? *Please tick* Yes ☐ No ☐

If yes, please state: Details – include medications

- Heart Problems ☐ Yes ☐ No ______________________
- Respiratory Problems (e.g. Asthma) ☐ Yes ☐ No ______________________
- Allergies ☐ Yes ☐ No ______________________
- Travel Sickness ☐ Yes ☐ No ______________________
- Blood Pressure ☐ Yes ☐ No ______________________
- Operations ☐ Yes ☐ No ______________________
- Epilepsy ☐ Yes ☐ No ______________________
- Drug Reactions (e.g. Penicillin allergy) ☐ Yes ☐ No ______________________
- Hepatitis B Injections ☐ Yes ☐ No ______________________
- Phobias ☐ Yes ☐ No ______________________
- Tetanus Injection (up to date) ☐ Yes ☐ No ______________________
- Other ☐ Yes ☐ No ______________________

Is your son/daughter suffering from an injury or condition, which is likely to be aggravated by competition? (If Yes, give details) ______________________________

Medicare Number ______________________ Expiry Date ______________________

Emergency Contacts

1. Name and Address ____

______________________________ Phone Number ______________________

2. Name and Address ____

______________________________ Phone Number ______________________