KKDA

Child Indemnity and Permission Form

This information is kept confidential and is solely for use by Krystal Kaye Designs

E: krystalkayedesigns@gmail.com
P: 0432 220 686

CHILD'S DETAILS	Date of Birth:
Name:	Phone Number:
Address:	Email: (optional)
	School Year

Parent or Guardian details	**Alternative emergency contact:**
Name:	Name:
Relationship to child:	Relationship to child:
Phone numbers to be used:	Phone number to be used:
Email:	Email:

Please give details of any person/s not permitted to contact or collect your child while in the care of programs conducted by Krystal Kaye Designs and any Court order related to such: .....

CONFIDENTIAL MEDICAL REPORT

THE INFORMATION BELOW IS REQUESTED TO ASSIST IN CASE OF ANY ILLNESS OR ACCIDENT, AND WILL BE HELD IN CONFIDENCE.

A) PLEASE TICK IF YOUR CHILD SUFFERS FROM ANY OF THE FOLLOWING:

[ ] HEART CONDITION
[ ] BLACKOUTS [ ] MIGRAINES
[ ] ASTHMA
[ ] DIABETES
[ ] ANAPHYLAXIS (PLEASE SPECIFY BELOW)
[ ] OTHER (PLEASE SPECIFY BELOW)

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B) IS YOUR CHILD PRESENTLY TAKING MEDICATION? IF YES, PLEASE STATE THE NAME OF THE MEDICATION, DOSAGE, ETC. .....

C) PLEASE TICK IF YOUR CHILD IS ALLERGIC TO ANY OF THE FOLLOWING:

[ ] PENICILLIN [ ] BEE STINGS
[ ] OTHER DRUGS (PLEASE SPECIFY BE.....

D) HELPFUL DETAILS IF AVAILABLE:

LAST TETANUS IMMUNIZATION:.....
MEDICARE NO: .....
MEDICAL/HOSPITAL FUND NAME:.....
CONTRIBUTION / MEMBER NO:.....
AMBULANCE COVER NO.....
NAME OF FAMILY DOCTOR: .....
PHONE: .....

PLEASE LIST ANY PHYSICAL OR SPECIAL NEEDS: (E.G. DIETARY REQUIREMENTS, FOOD ALLERGIES)

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I CONSENT TO MY CHILD PARTICIPATING IN AN AUTHORISED PROGRAM WITH KRYSTAL KAYE DESIGNS.

I WILL ENCOURAGE MY CHILD TO ATTEND AND PARTICIPATE AND TO COOPERATE WITH THE LEADERS AND OTHER CHILDREN.

I AUTHORISE THE LEADER/S IN CHARGE OF THE PROGRAM, WHERE IT IS IMPRACTICAL TO COMMUNICATE WITH ME, TO ARRANGE FOR MY CHILD TO RECEIVE SUCH FIRST AID, MEDICAL OR SURGICAL TREATMENT BY A QUALIFIED MEDICAL PRACTITIONER AS THE LEADER MAY DEEM NECESSARY AT ANY TIME DURING THE ACTIVITIES OF THE PROGRAM. I ACCEPT RESPONSIBILITY FOR PAYMENT OF ALL EXPENSES ASSOCIATED WITH SUCH TREATMENT.

I AGREE TO INDEMNIFY AND HOLD HARMLESS THE KRYSTAL KAYE DESIGNS AND PROGRAM LEADERS AGAINST ALL CLAIMS, DEMANDS, SUITS AND LIABILITY OF WHATEVER NATURE AND HOWSOEVER ARISING OUT OF THE INJURY TO THE CHILD, AND THE RELEVANT ACTIVITY BEING UNDERTAKEN.

PLEASE INDICATE BELOW:

[YES] [NO] I GIVE PERMISSION FOR PHOTOGRAPHS AND VIDEO FOOTAGE TO BE TAKEN OF MY CHILD DURING KRYSTAL KAYE PROGRAMS TO BE USED FOR PROMOTION PURPOSES.
[YES] [NO] FACEBOOK PROMOTION
[YES] [NO] INSTAGRAM PROMOTION
[YES] [NO] PRINT MEDIA E.G. NEWSLETTERS/REPORTS

SIGNATURE OF PARENT/GUARDIAN

SIGNATURE.....
PRINT NAME: .....