Authorisation to Contact Medical Practitioner(s) #4

This form is to be completed by the parent/guardian.

Student Name	

I understand that the school may need to discuss the implications of my child's medical condition so that the school can support my child during school hours and during activities conducted under the auspices of the school. I hereby give my permission for the school to contact my child's medical practitioner(s) to obtain necessary information.

Medical practitioner information:

Doctors Name	
Surgery/Centre	
Address	
Phone	
Fax (if known)	
This doctor is the most relevant for information about my child on	

Doctors Name	
Surgery/Centre	
Address	
Phone	
Fax (if known)	
This doctor is the most relevant for information about my child on	

The following is ***only required*** if Dr Paul Duffy is your noted Paediatrician.

Doctors Name	Dr Paul Duffy
Surgery/Centre	Kingsway Medical Centre
Address	729 Pittwater Rd, Dee Why NSW 2099
Phone	(02) 9982 8388
I agree to the teachers discussing current progress and classroom behaviours of my child with Dr Paul Duffy. I also agree to Dr Paul Duffy arranging a time with the school to observe my child when this is required. **Signed : X**_____	

I understand the information so disclosed may be discussed by the principal of the school with other members of the school staff, as is necessary, enabling staff to care for my child. Permission is given until I withdraw my authority in writing.

Parent/Carer Name:	
Date:	

X _____
Parent/Carer Signature

115 Fisher Rd, Dee Why NSW 2099
Phone: 9981 5222 Fax: 9982 5439 Email: fisherrd-s.school@det.nsw.edu.au