CLIENT AUTHORISATION FORM

Client's Name .....

Mobile Phone Nos: *.....*.....

Important information
Does you child suffer from allergies or have certain special needs?
If **YES** please record the details below:

CHILD'S NAME	AGE	ALLERGIES	ANY SPECIAL NEEDS OR DIETARY

In order for us to provide professional, responsible care for your children, we require your written authorisation to permit us to carry out the following functions:
Please circle **YES / NO / or N/A** to indicate your permission for your Carer to:

Seek immediate medical or dental treatment from any available Doctor, Dentist ,Hospital or	YES / NO or N/A
Administer basic medication to any child/adult under care.	YES / NO or N/A
Take the child/adult under care on an excursion or outing. (IF 'YES" please specify: .....)	YES / NO or N/A
Allow the adult/children under care to participate in water based activities, including swimming in any pool.	YES / NO or N/A

SIGNATURE of PARENT / GUARDIAN ..... DATE: .....

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