



THE OAKS PUBLIC SCHOOL

5 Burragorang Street, The Oaks 2570

Phone: (02) 4657 1185

Fax: (02) 4657 1704

Email: theoaks-p.school@det.nsw.edu.au

School Concert

23rd August, 2017

Dear Parents/Caregivers,

Our bi-annual school concert will be held at a new venue this year. Students will be catching a bus to and from Camden Civic Centre for the matinée performance. The school will be covering the cost of the bus. However, all students will require a signed permission note in order for them to participate in this performance.

Details are listed below:

Date: Thursday 7th September, 2017

Time: Students arrive at school by **9.15am**

Bus leaves at 9.30am

Bus returns to school approximately 3.00pm

Where: Camden Civic Centre

Cost: \$0

What to wear: **Concert clothes** - students are to wear their clothing to school.

What to bring: Recess, Lunch, drinks

* If you wish to take your child/children home after the Matinee performance you will need to sign your child out before leaving. If a child is going home with an adult other than their parent/s or carer, a signed permission note needs to be handed to their teacher explaining who they are going home with.

Please complete the permission note and medical form below and return it on or before 30th August, 2017. If you have any questions please do not hesitate to ask.

Mrs Levings
Concert Committee

Mrs Leeanne Godkin
Relieving Principal

School Concert

I give permission for my child to attend the School Concert at the Camden Civic Centre on Thursday 7th, September 2017. I understand that my child _____ of class _____ will travel to and from the Camden Civic Centre by bus.

Parent/Guardian Signature

Parent/Guardian Name

Date



THE OAKS PUBLIC SCHOOL

SCHOOL CONCERT 7TH SEPTEMBER, 2017



MEDICAL INFORMATION FORM

The information requested below will help to provide the best possible care of your child.

- Providing this information is not obligatory, but its absence may prevent your child from participation;
- It will be used to minimise risks associated with this excursion;
- It will be seen only by those persons providing health care treatment;
- It will be stored securely and destroyed after the legal time limit has expired

Student Name: _____ Class: _____

Parent or Caregiver Contact Details

Name: _____

Address: _____

Home Phone: _____ Work: _____ Mobile: _____

Medicare Number: _____

Doctor Contact Details

Name: _____

Address: _____

Doctor's Telephone: 1. _____ 2. _____

Emergency Contact/s Details (nominated by the parent/caregiver as alternate contact)

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

List existing **medical conditions or illnesses** (including asthma, diabetes, epilepsy, allergies, etc). Outline the treatment for each.

Outline special dietary needs including possible reaction to inappropriate diet

Medication/s to be administered during the excursion. Include name of medication for administration, time of administration and any possible reactions

Signature: _____ Date: _____