**Outdoor School – 15 Mile Creek**

# Parent Consent Form — Valid 2021 & 2022

**Student's Full Name:** _____

**Parent/Guardian Consent – please circle as appropriate – (if left blank we will assume yes is the response):**

The information about your child/ward and family collected through this Enrolment Form will only be shared with school staff who need to know to enable our school to educate or support your child/ward, or to fulfil legal obligations including duty of care, anti-discrimination law and occupational health and safety law. The information collected will not be disclosed beyond the Department of Education and Training without your consent, unless such disclosure is lawful. For more about information-sharing and privacy, see our school's privacy policy: Data will be kept permanently as per the 2018 Retention and Disposal Authority for Records of School Records 3.3.1 Summary Enrolment Records requires. The collection and use of the students personally identifiable information via consent forms provided within the handbook and stored via Cumulus is done in accordance with the Privacy and Data Protection Act 2014. Data will be kept permanently as per the 2018 Retention and Disposal Authority for Records of School Records 3.3.1 Summary Enrolment Records requires.

| | | |
|---|---|---|
| I agree to my child/ward using the internet and computer network at 15 Mile Creek in accordance with the same internet student user's agreement that applies at their current school. | Yes | No |
| I also consent to my child/ward being photographed and/or visual images of my child/ward being taken whilst at 15 Mile Creek by the DET. I also consent to these photos being used for use in the school's publications, the school's social media accounts and the school's website, for publicity purposes without acknowledgment and without being entitled to any remuneration or compensation. | Yes | No |
| Is English your child/ward's main language? | Yes | No |
| Is your child/ward of Aboriginal or Torres Strait Islander origin? | Yes | No |
| Has your child/ward been away from home before? | Yes | No |
| I authorise the teacher in charge to administer paracetamol as per the Outdoor School protocol. | Yes | No |

I agree to my child/ward's attendance at the Outdoor School - 15 Mile Creek **on _____/_____/_____ (Starting Date)**

I also agree to them taking part in any excursion or activities arranged for students in connection with the school program. I have read the **Parent/Guardian & Student Booklet** and understand the program contains potentially hazardous activities in remote areas subject to natural hazards and severe weather.

I will notify the school if my child/ward is in contact with any infectious disease within four weeks of departure date. In the event of any illness or accident, where it is impracticable to communicate with me, I authorise the teacher in charge to consent to my child/ward receiving such medical or surgical treatment as may be deemed necessary. I accept responsibility for payment of any expenses thus incurred. In the event of my child/ward being unable to accompany the rest of the group home due to ill health or accident I will make the necessary arrangements in liaising with the School Principal for their return.

**I agree to ensure that my child/ward's mobile devices (phones, tablets, iPods etc.) remain at home whilst they attend this program.**

Should my child/ward violate the rules of the school to the extent that the teacher in charge in consultation with the Principal of Outdoor School 15 Mile Creek considers that they should be sent home, I agree to organise this withdrawal and fully cover the transport costs involved in this process.

_____

**Parent/Guardian's Full Name (please print)**

_____ _____

**Parent/Guardian's Signature** **Date**

I have read the Outdoor School Student Code of Cooperation and I hereby undertake that while travelling to and from the school and while in attendance I shall behave in a good and proper manner and shall observe whatever rules are decided on as best for the welfare of all.

_____ _____

**Student's Signature** **Date**

***Cancellation or Withdrawal***

*The Department of Education and Training (DET) reserves the right to cancel a program for any reason. In the event of a student's application being withdrawn prior to the commencing date of the program the DET through the Principal reserves the right to make a refund only where a reasonable excuse for withdrawal is offered. No refund will be made where a student leaves during the program except in the case of illness, and then only on a pro rata basis.*

**Outdoor School – 15 Mile Creek**

# Medical Information Form — Valid 2021 & 2022

This information is intended to assist Outdoor School in case of any medical emergency with your child/ward. All information is held in confidence.

School: _____ Year Level / Visiting Staff: _____

Student Full Name: _____

Student Date of Birth: _____ Student Gender: Female ☐ Male ☐ Gender Diverse ☐

Parent/Guardian Full Name: _____

Address: _____ Postcode: _____

Parent/Guardian Mobile Phone: _____ Other Phone: _____

Home Email Address: _____

Medicare No: _____ Valid to: _____ Child's Number (eg. 2): _____

Health Insurance Fund: _____ Member No: _____ Ambulance Subscriber: Yes No

| Tick | Item | Details |
|---|---|---|
| | Diabetes | |
| | Dietary Requirements | |
| | Dizzy Spells/Blackouts | |
| | Fits Of Any Type | |
| | Hay Fever | |
| | Heart Condition | |
| | Migraines | |
| | Physical Difficulties | |
| | Previous Injuries - When | |
| | Sleepwalking | |
| | Travel Sickness | |
| | Other | |

*Please tick the box on the left if your child/ward suffers any of the following:*

| | | |
|---|---|---|
| | Anaphylaxis | If ticked, you **MUST** attach the appropriate completed Anaphylaxis Action Plan.<br>*Please state below who will be responsible for carrying the Epipen?*<br>*Responsible person is:* |
| | Allergies | If ticked, you **MUST** complete and attach the Allergic Reactions Action Plan |
| | Asthma | If ticked, you **MUST** complete and attach Asthma Update Form along with your child's personal Asthma Action Plan. |

| | |
|---|---|
| **Year of Last Tetanus Immunisation** (If known): | |

**Medication** – Is your child/ward presently taking tablets and or medicine? **YES / NO** (If yes please detail below.)

| Condition | Medication | Dosage | When given & instructions. |
|---|---|---|---|
| | | | |
| | | | |

**Swimming Ability:** please tick the distance your child/ward can swim comfortably.

☐ Cannot Swim ☐ Weak Swimmer (<50m) ☐ Fair Swimmer (50-100m) ☐ Competent Swimmer (100-200m) ☐ Strong Swimmer (200m+)

_____ _____

**Signature of Parent/Guardian:**

DET requires this consent to be signed for all students and teachers attending school excursion

# Asthma Update Form – School Camps & Excursions

## School Camp and Excursion

Asthma Update Form

Asthma Foundation VIC

Name: _____

Date of birth: _____

Confirmed Triggers

| | |
|---|---|
| Has the student been hospitalized due to asthma, had an acute asthma attack or worsening asthma in the last two weeks? | ☐ Yes ☐ No |
| Has the student's asthma medications changed in the last two weeks? | ☐ Yes ☐ No |
| Is the student well enough to attend camp/excursion? | ☐ Yes ☐ No |

**This form is to be completed by parents/carers of students with asthma prior to an excursion or camp. The form is to be attached to a copy of the student's Asthma Action Plan and brought with students to the camp or excursion. Please provide as much detail as possible.**

### OTHER MEDICAL CONDITIONS

Has the student had any other illness in the last two weeks? ☐ Yes ☐ No

If YES, please provide details:

Nature of illness? _____ When? _____

Severity? _____ Has this affected their asthma? ☐ Yes ☐ No

### ALLERGIC RHINITIS (HAY FEVER)

Does the student hay fever? ☐ Yes ☐ No Does the student have an action plan for hay fever? ☐ Yes ☐ No

Confirmed Triggers for hay fever

Medication ..... Device ..... Dose ..... When .....

Treatment .....

### ADDITIONAL ASTHMA MEDIC ATION REQUIREMENTS

1. Medication ..... Device ..... Dose ..... When .....

Instructions for use .....

2. Medication ..... Device ..... Dose ..... When .....

Instructions for use .....

Doctors Name: _____

Phone: _____

Address:

Emergency Contact: _____

Phone: _____

The information provided on this plan is true and correct.

Signed: _____

Date: _____

Additional information:

_____

_____

_____

_____

_____

_____

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# Action Plan - Allergic Reactions

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

## ACTION PLAN FOR Allergic Reactions

Name:
Date of birth:

Photo

Confirmed allergens:

Asthma Yes ☐ No ☐

Family/emergency contact name(s):

Work Ph:
Home Ph:
Mobile Ph:

Plan prepared by:
Dr:
Signed:
Date:

Note: The ASCIA Action Plan for Allergic Reactions is for people with mild to moderate allergies, who need to avoid certain allergens.

For people with severe allergies (and at risk of anaphylaxis) there are ASCIA Action Plans for Anaphylaxis, which include adrenaline autoinjector instructions.

Instructions are also on the device label and at: www.allergy.org.au/anaphylaxis

Note: This is a medical document that can only be completed and signed by the patient's treating medical doctor and cannot be altered without their permission.

© ASCIA 2014. This plan was developed by ASCIA

## MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

## ACTION

- **For insect allergy, flick out sting if visible. Do not remove ticks.**
- Stay with person and call for help
- Give medications (if prescribed)
  Dose:
- Phone family/emergency contact

**Mild to moderate allergic reactions may or may not precede anaphylaxis**

**Watch for any one of the following signs of anaphylaxis**

## ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness or collapse
- Pale and floppy (young children)

## ACTION

1. **Lay person flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit.**
2. **Give adrenaline autoinjector if available.**
3. **Phone ambulance* 000 (AU), 111 (NZ), 112 (mobile)**
4. **Phone family/emergency contact**

**Commence CPR at any time if person is unresponsive and not breathing normally. If uncertain whether it is asthma or anaphylaxis, give adrenaline autoinjector FIRST, then asthma reliever.**

* Medical observation in hospital for at least 4 hours is recommended after anaphylaxis

Additional information

# Action Plan - Anaphylaxis Reaction

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

## ACTION PLAN FOR Anaphylaxis

For use with EpiPen® Adrenaline Autoinjectors

Name:
Date of birth:

Photo

Confirmed allergens:

Asthma Yes ☐ No ☐

Family/emergency contact name(s):

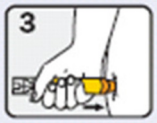
Work Ph:
Home Ph:
Mobile Ph:

Plan prepared by:
Dr:
Signed:
Date:

### How to give EpiPen®

Form flat around EpiPen® and PULL OFF BLUE SAFETY RELEASE.

PLACE ORANGE END against outer mid-thigh (with or without clothing).




PUSH DOWN HARD until a click is heard or felt and hold in place for 10 seconds.

REMOVE EpiPen®. Massage injection site for 10 seconds.

Instructions are also on the device label and at:
www.allergy.org.au/anaphylaxis

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### MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

### ACTION

- **For insect allergy, flick out sting if visible. Do not remove ticks.**
- Stay with person and call for help
- Locate EpiPen® or EpiPen® Jr
- Give other medications (if prescribed) ..... Dose: .....
- Phone family/emergency contact

**Mild to moderate allergic reactions may or may not precede anaphylaxis**

**Watch for any one of the following signs of anaphylaxis**

### ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness or collapse
- Pale and floppy (young children)

### ACTION

1. **Lay person flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit.**
2. **Give EpiPen® or EpiPen® Jr**
3. **Phone ambulance* 000 (AU), 111 (NZ), 112 (mobile)**
4. **Phone family/emergency contact**
5. **Further adrenaline doses may be given if no response after 5 minutes (if another adrenaline autoinjector is available)**

**If in doubt, give adrenaline autoinjector**

**Commence CPR at any time if person is unresponsive and not breathing normally.**
**If uncertain whether it is asthma or anaphylaxis, give adrenaline autoinjector FIRST, then asthma reliever.**

EpiPen® is generally prescribed for adults and children over 5 years.
EpiPen® Jr is generally prescribed for children aged 1-5 years.
*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

Additional information .....

Note: This is a medical document that can only be completed and signed by the patient's treating medical doctor and cannot be altered without their permission.