Outdoor School – Bogong

Parent Consent and Acceptance Form

Student's Full Name: _____

Parent/Guardian Consent – please circle response below as appropriate – (if left blank we will assume yes is the response):
The information about your child/dependant and family collected through this form will only be shared with school staff who need to know to enable our school to educate or support your child/dependant, 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 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/dependent using the internet and computer network at Bogong in accordance with the same internet student user's agreement that applies at their current school.	Yes	No
I also consent to my child/dependent being photographed and/or visual images of my child/dependent being taken whilst at Bogong 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/dependent's main language?	Yes	No
Is your child/dependent of Aboriginal or Torres Strait Islander origin?	Yes	No
Has your child/dependent 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 understand that I will be required to immediately collect my child/dependent from Outdoor School if they are unwell and unable to participate in the program while at Outdoor School.	Yes	No
I understand that if my child/dependent does not comply with the Outdoor School Code of Cooperation that I will be required to collect my child/dependent from Outdoor School.	Yes	No

I have read the **Parent/Guardian and Student Booklet** and the **Outdoor School Enrolment/Acceptance Policy** included in the booklet and I agree to my child/dependant's attendance at the Outdoor School - Bogong on:

_____/_____/_____ (Starting Date)

I have read the **Parent/Guardian and Student Booklet** and I agree to them taking part in any excursion or activities arranged for students in connection with the school program. I 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/dependant 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/dependant 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/dependant 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/dependant's mobile devices (phones, tablets, iPods etc.) remain at home whilst they attend this program.

Should my child/dependant violate the rules outlined in the **Outdoor School Student Code of Cooperation** to the extent that the teacher in charge in consultation with the Principal of Outdoor School Bogong 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 (DE) 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 DE 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 – Bogong

Medical Information Form

If there is a situation or incident which requires first aid to be administered to your child, school staff will administer first aid that is reasonably necessary and appropriate to their level of training. School staff will also seek emergency medical attention for your child if it is considered reasonably necessary. Any costs associated with student injury rest with parents/carers unless the Department of Education is liable in negligence (liability is not automatic).
In the event that your child needs medical attention, school staff will contact you as soon as practically possible.

School: _____ Year Level or Visiting Staff: _____

Full Name: _____

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

Parent/Guardian or Next of Kin Full Name: _____

Address: _____

Parent/Guardian or Next of Kin Mobile Phone: _____ Other Phone: _____

Home Email Address: _____

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

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

☐ Anaphylaxis | If ticked, you **MUST** attach the appropriate completed Anaphylaxis Action Plan.
Please state who will be responsible for carrying the Epipen

☐ Allergies | If ticked, you **MUST** complete and attach the Allergic Reactions Action Plan.

☐ Asthma | If ticked, you **MUST** provide your child's personal Asthma Action Plan. A suitable blank form is enclosed.

☐ Other Health Care Needs | Please provide an Action Plan if your child/dependant needs medical or health related support at school (e.g. diabetes management).

☐ Support for Learning | Does your child/dependant have additional needs and require support?
If ticked you must complete the **Student Learning Needs Form.**

Year of Last Tetanus Immunisation (If known):	

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

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

Medication – Is your child/dependant presently taking tablets and or medicine? ☐ Yes ☐ No

If yes, please complete the Medication Authority Form.

Parent/Guardian Signature: _____ **Date:** _____

Outdoor School – Bogong

Student Learning Needs Form

ONLY complete this form if your child has specific additional learning needs. Students with an Individual Learning Plan or an Education Action Plan should have this form completed as well as including their plan.

Student Name: _____

Please indicate any adjustments that may assist your child/dependant to participate at school:

Has your child/dependant had a disability assessment before?
If yes – please specify outcome below. ☐ Yes ☐ No

Has your child/dependant received individualised disability funding before?
If yes, please specify below. ☐ Yes ☐ No

Has any previous education provider prepared a documented plan to support your child/dependants additional learning needs? If yes, please provide details below. ☐ Yes ☐ No

Does your child/dependant have additional needs in one of the following areas? ☐ Yes ☐ No

Speech/Language: ☐ No ☐ Yes (please specify): _____

Physical: ☐ No ☐ Yes (please specify): _____

Cognitive/Learning: ☐ No ☐ Yes (please specify): _____

Social/Emotional: ☐ No ☐ Yes (please specify): _____

Is the student on: ☐ An Individual Learning Plan ☐ An Education Plan

Please list below other relevant information that would assist us to work with your child/dependant in a residential environment.

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian: **Date:**

Photo (optional)

ASTHMA ACTION PLAN

Take me when you visit your doctor

ASTHMA AUSTRALIA

Name:

Plan date: **Review date:**

Doctor details:

EMERGENCY CONTACT

Name:

Phone:

Relationship:

WELL CONTROLLED is **all** of these...

- ☑ needing reliever medicine no more than 2 days/week
- ☑ no asthma at night
- ☑ no asthma when I wake up
- ☑ can do all my activities

Peak flow reading (if used) above _____

TAKE preventer

Name

morning ____ **night** ____ puffs/inhalations

- Use my preventer, even when well controlled
- Use my spacer with my puffer

TAKE reliever

Name

____ puffs/inhalations as needed ____ **puffs/inhalations 15 minutes before exercise**

- Always carry my reliever medicine

FLARE-UP Asthma symptoms getting worse such as **any** of these...

- needing reliever medicine more than usual OR more than 2 days/week
- woke up overnight with asthma
- had asthma when I woke up
- can't do all my activities

Peak flow reading (if used) between _____ and _____

My triggers and symptoms

TAKE preventer

Name

morning ____ **night** ____ puffs/inhalations for ____ days then back to **well controlled** dose

TAKE reliever

Name ____ puffs/inhalations as needed

START other medicine

Name/dose/days/other treatments

MAKE appointment to see my doctor same day or as soon as possible

SEVERE Asthma symptoms getting worse such as **any** of these...

- reliever medicine not lasting 3 hours
- woke up frequently overnight with asthma
- had asthma when I woke up
- difficulty breathing

Peak flow reading (if used) between _____ and _____

My triggers and symptoms

TAKE preventer

Name

morning ____ **night** ____ puffs/inhalations for ____ days then back to **well controlled** dose

TAKE reliever

Name ____ puffs/inhalations as needed

START other medicine

Name/dose/days/other treatments

MAKE appointment to see my doctor TODAY

- If unable to see my doctor, visit a hospital

OTHER INSTRUCTIONS

Other medicines, treatments, dose, duration, etc

EMERGENCY is **any** of these...

- reliever medicine not working at all
- can't speak a full sentence
- extreme difficulty breathing
- feel asthma is out of control
- lips turning blue

Peak flow reading (if used) below _____

1 000 **CALL AMBULANCE NOW**

Dial Triple Zero (000)

2 **START ASTHMA FIRST AID**

Turn page for Asthma First Aid

If you are using a dual purpose reliever, your doctor will discuss the correct plan for you.

v19 Updated 13 October 2023

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

ACTION PLAN FOR Anaphylaxis

Name: _____ Date of birth: DD / MM / YYYY

Confirmed allergen(s): _____

_____

Family/emergency contact(s):

1. _____ Mobile: _____

2. _____ Mobile: _____

Plan prepared by: _____ (doctor or nurse practitioner) who authorises medications to be given, as consented by the parent/guardian, according to this plan.

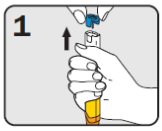
Signed: _____ Date: DD / MM / YYYY

Antihistamine: _____ Dose: _____

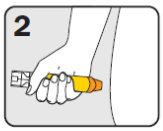
This plan does not expire but review is recommended by: DD / MM / YYYY

How to give adrenaline (epinephrine) injectors

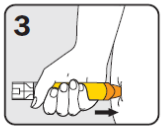
EpiPen®



Form fist around EpiPen® and PULL OFF **BLUE** SAFETY RELEASE



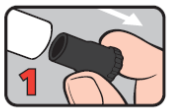
Hold leg still and PLACE **ORANGE** END against outer mid-thigh (with or without clothing)



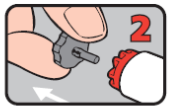
PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds REMOVE EpiPen®

EpiPen® is prescribed as follows:
EpiPen® Jr (150 mcg) for children 7.5-20kg
EpiPen® (300 mcg) for children over 20kg and adults

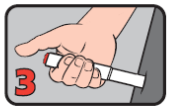
Anapen®



PULL OFF **BLACK** NEEDLE SHIELD



PULL OFF **GREY** SAFETY CAP from red button



PLACE NEEDLE END FIRMLY against outer mid-thigh at 90°angle (with or without clothing)

PRESS **RED** BUTTON so it clicks and hold for 3 seconds. REMOVE Anapen®

Anapen® is prescribed as follows:
Anapen® 150 Junior for children 7.5-20kg
Anapen® 300 for children over 20kg and adults
Anapen® 500 for children and adults over 50kg

MILD TO MODERATE ALLERGIC REACTIONS

SIGNS:

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

Mild to moderate allergic reactions may not always occur before anaphylaxis

ACTIONS:

- Stay with person, call for help
- Locate adrenaline injector
- **Give antihistamine - see above**
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)

Watch for ANY ONE of the following signs:

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

ACTIONS FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright

2 GIVE ADRENALINE INJECTOR

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Further adrenaline may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE INJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS GIVE ADRENALINE INJECTOR FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

If adrenaline is accidentally injected, phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

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ACTION PLAN FOR Allergic Reactions

Name: _____ Date of birth: DD / MM / YYYY

Confirmed allergen(s): _____

_____

Family/emergency contact(s):

1. _____ Mobile: _____

2. _____ Mobile: _____

Plan prepared by: _____ (doctor or nurse practitioner) who authorises medications to be given, as consented by the patient or parent/guardian, according to this plan.

Signed: _____ Date: DD / MM / YYYY

Antihistamine: _____ Dose: _____

This plan does not expire but review is recommended by: DD / MM / YYYY

This ASCIA Action Plan for Allergic Reactions is for people who have allergies but do not have a prescribed adrenaline (epinephrine) injector.

MILD TO MODERATE ALLERGIC REACTIONS

SIGNS:

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

Mild to moderate allergic reactions may not always occur before anaphylaxis

ACTIONS:

- Stay with person, call for help
- **Give antihistamine - see above**
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)

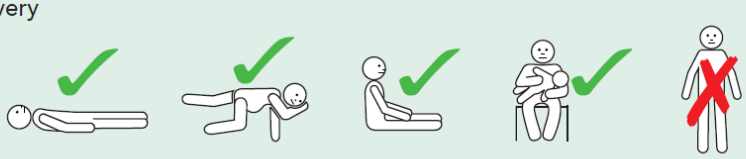
Watch for ANY ONE of the following signs:

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

ACTIONS FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright



2 GIVE ADRENALINE INJECTOR IF AVAILABLE

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE INJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

Adrenaline injector doses are:

- 150 mcg for children 7.5-20kg
- 300 mcg for children over 20kg and adults
- 300 mcg or 500 mcg for children and adults over 50kg

Instructions are on device labels.

ALWAYS GIVE ADRENALINE INJECTOR FIRST and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

If adrenaline is accidentally injected, phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

Medication Authority Form

For students requiring medication to be administered at school. This form is not required if a student does not have any medications. This form should, be signed by the student's medical/health practitioner for all medication to be administered at school but schools may proceed on the signed authority of parents in the absence of a signature from a medical practitioner.

- **For students with asthma**, Asthma Action Plan
- **For students with anaphylaxis**, an ASCIA Action Plan for Anaphylaxis

Please only complete the sections below that are relevant to the student's health needs. If additional advice is required, please attach it to this form.

Student Details:

Name of school: _____

Name of student: _____ Date of Birth: _____

MedicAlert Number (if relevant): Review date for this form:

Medication to be administered at school:

Name of Medication	Dosage (amount)	Time/s to be taken	How is it taken? (eg oral/topical)	Dates to be administered	Supervision required
				Start: / / End: / / **OR** ☐ Ongoing medication	☐ No – student self-managing ☐ Yes ☐ remind ☐ observe ☐ assist ☐ administer
				Start: / / End: / / **OR** ☐ Ongoing medication	☐ No – student self-managing ☐ Yes ☐ remind ☐ observe ☐ assist ☐ administer

Medication delivered to the school:

Please indicate if there are any specific storage instructions for any medication:

Please ensure that medication delivered to the school:

☐ Is in its original package.

☐ The pharmacy label matches the information included in this form.

Supervision required:

Students in early years will generally need supervision of their medication and health care management. In line with their age, stage of development and capabilities, older students can take responsibility for their health care. Self-management should be agreed to by the student, their parents, the school and the student's medical practitioner. Please describe what supervision or assistance is required by the student when taking medication at school (e.g. remind, observe, assist or administer):

Monitoring effects of medication:

Please note: School staff ***do not*** monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

Privacy Statement:

We collect personal and health information to plan for and support the health care needs of our students. Information collected will be used and disclosed in accordance with the Department of Education and Training's privacy policy which applies to all government schools (available at: http://www.education.vic.gov.au/Pages/schoolsprivacypolicy.aspx) and the law.

Authorisation to administer medication in accordance with this form:

Name of parent/carer: _____

Signature: Date:

Name of medical/health practitioner: _____

Professional Role:

Signature: Date: