Outdoor School – Bogong

Parent Consent Form — Valid 2018

Student's Full Name: ____

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

I agree to my child 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 being photographed and/or visual images of my child 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's main language?	Yes	No
Is your child of Aboriginal or Torres Strait Islander origin?	Yes	No
Has your child 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's attendance at the Outdoor School - Bogong on _______/_____/__________ (Starting Date)

I also agree to him/her taking part in any excursion or activities arranged for students in connection with the school program. I have read the **Parent & 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 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 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 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 his/her return.

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

Should my son/daughter violate the rules of the school to the extent that the teacher in charge in consultation with the Principal of Outdoor School Bogong considers that he/she 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 – Bogong

Medical Information Form — Valid 2018

For Students & Visiting Teacher (VT) to fill in

This information is intended to assist Outdoor School – Bogong in case of any medical emergency with your child or a VT.
All information is held in confidence.

School: ______________________ **Year Level/VT** ____________

Student Full Name: ______________________ **Date of Birth:** ________ **Gender:** **Male** **Female**

Parent/Guardian/Contact Person's Full Name: ______________________ **D.O.B.** ____________

Address: ______________________

Mobile Phone: ______________________ **Other Phone:** ______________________

Home Email Address: ______________________

Medicare No: ______________________ **Valid to:** _____/_____ **Child's Number (e.g. 2, 3, 4):** ________

Medical/Hospital 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	
	Sleepwalking	
	Travel Sickness	
	Other	

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

	Anaphylaxis	If ticked you **MUST** attach the appropriate completed Anaphylaxis Action Plan.
Responsible person is:		*Please state below 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** complete and attach Asthma Update Form along with your child's personal Asthma Action Plan.

Year of Last Tetanus Immunisation:		(Note: Tetanus immunisation is normally given at 5 years of age as Triple Antigen or CDT and at 15 years of age — as ADT.)

Medication – Is your child 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 can swim comfortably.

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

______________________________________ ____________________

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

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

Asthma Foundation Victoria

School Camp and Excursions
Asthma Update Form

Student Name:

____

Photo

☐ Student needs to pre-medicate prior to exercise

☐ Student can administer own medication

First family/emergency contact name:

____

Work Ph: ______________________

Home Ph: ______________________

Mobile: ______________________

Second family/emergency contact name:

____

Work Ph: ______________________

Home Ph: ______________________

Mobile: ______________________

Doctors Name:

____

Phone: ______________________

The information provide on this plan is true and correct.

Signed (parent or guardian):

____

Date: ______________________

Additional information:

____

____

____

____

____

____

____

____

____

© The Asthma Foundation of Victoria 2016.

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.

STUDENTS MEDICAL DETAILS

Has the student been hospitalised 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

Has the student had any other illness in the last two weeks? Yes No
If YES, please provide the details:

Nature of illness: ______________________________

When? ______________________________

Severity? ______________________________

Has this affected their asthma? Yes No

Is the student well enough to attend camp/excursion? Yes No

ADDITIONAL ASTHMA MEDICATION REQUIREMENTS

Example

Medication	Device	Dose	When
......*Flixotide*.........	*puffer and spacer*	...*1 puff*.......	..*twice daily*....

Instructions for use

......*1 puff in the morning and 1 puff of a night*..........................

....

Please provide as much detail as possible

1.

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

Instructions for use

....

....

2.

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

Instructions for use

....

....

3.

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

Instructions for use

....

....

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

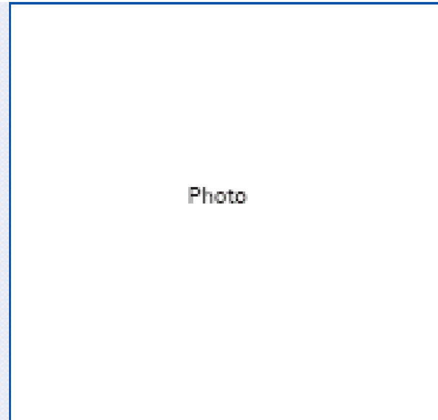
Additional information

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:

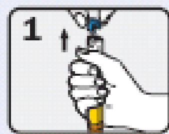
Asthma Yes ☐ No ☐

Family/emergency contact name(s):

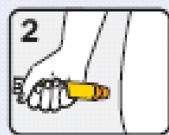
Work Ph:
Home Ph:
Mobile Ph:

Plan prepared by:
Dr:
Signed:
Date:

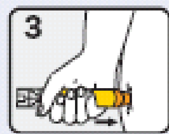
How to give EpiPen®



Form fist 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.