



FAITHFULNESS IN SERVICE

BISHOP DRUITT COLLEGE

COFFS HARBOUR

Year 9 Outdoor Education Program

General Information and Permission Form

Please complete and return to:

- the **Secondary Office** by Monday 11 June 2010.

Do not detach any part of this sheet.

Student's Surname: _____ Student's First Name: _____

Dietary requirements

Please outline any special dietary requirements.

Mobility requirements

Please outline any assistance the student may require regarding mobility.

Acknowledgement

Do not detach

I _____ (Parent/Guardian's name) acknowledge that
_____ (Student's name) will be attending the Year 9 camp in the
Nymboida region from 8 August – 14 August 2010.

Parent/Guardian signature: _____ Date: _____

Bishop Druitt College Yr 9 Outdoor Education Program

Confidential

Name of Participant _____ Sex _____

Address _____ Pcode _____

Phone _____ Date of birth _____

School Bishop Druitt College, Year 9 Camp.

Next of kin _____ Relationship _____

24 hour emergency phone(s) _____

Family doctor _____ Phone _____

Address _____ Medicare no _____

Private Healthcare fund _____ M'ship no _____

The following may prove useful for Inter-Action staff in the event of a medical emergency or in determining a participant's fitness for a given activity.

Does the participant suffer from: (please tick)

- | | | | | | | | |
|------------------|--------------------------|-----------------|--------------------------|-----------------------------|--------------------------|----------|--------------------------|
| Fits of any type | <input type="checkbox"/> | Heart condition | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Migraine | <input type="checkbox"/> |
| Dizzy spells | <input type="checkbox"/> | Sleep walking | <input type="checkbox"/> | Blackouts | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> |
| Travel sickness | <input type="checkbox"/> | Disability | <input type="checkbox"/> | Recent or recurrent illness | <input type="checkbox"/> | | |

Behavioural or emotional disorders _____

Normal treatment for each condition _____

Other (attach details if necessary) _____

Asthma & allergy sufferers only: Please fill out & attach separate forms:

Asthma form attached (tick) (Please fill out the separate forms attached)

Allergy form attached (tick) (Please fill out the separate forms attached)

Allergies:

Has the participant ever taken analgesics? (Panadol, Aspirin) Yes _____ No _____

Was there an allergic reaction to these? Yes _____ No _____

Any known allergies to: Penicillin Other drugs Food Plants Animals Which drugs? _____ Anything else? _____

What special care is recommended?

Year of last tetanus booster: _____

Swimming ability:

- Unable nothing more than a dog paddle
- Poor strokes, only limited ability beyond domestic swimming pool
- Good strong swimmer, able to confidently swim at least 50 metres in a variety of water conditions, surf, lakes, rivers
- Excellent able to swim 100m confidently or 50m fully clothed

All prescribed medication (except asthma puffers) must be handed to the teacher/supervisor in charge before the commencement of the program. Such medication must be in the original labelled pharmacy bottle with “use by” date, directions and be accompanied by written instructions including name, dosage and times to be taken.

Due to legal constraints, school, agency or Inter-Action staff are not permitted to administer analgesics (Panadol, Asprin etc). A letter from the participant’s doctor stating that there is no allergy **may** assist in the case of an emergency.

- I _____ being parent/guardian of the above-mentioned participant declare that I understand that the activities may involve running, jumping, water and use of specially designed adventure equipment thus exposing my son/daughter to situations and physical activity not encountered in a classroom.
- I acknowledge that while Inter-Action and its staff and associated instructors will make every reasonable effort to minimise exposure to known risks, all hazards and dangers associated with these activities cannot be foreseen or may be beyond the control of Inter-Action, its staff or associated instructors.
- I declare that I have read the **Activity Descriptions** and that I understand what the program involves. Accepting that risk, and the fact that at all times involvement will be voluntary, I hereby indemnify Inter-Action Experiential Learning Pty Ltd, its staff or instructors against any claim for accident or injury to my child while involved in such activities.
- I further authorise that any duly authorised agents of Inter-Action Experiential Learning Pty Ltd in the event of any injury or illness, and where it is not possible or reasonable to obtain my consent at the time, to engage any medical practitioner or hospital facilities or accommodation. In this event I agree to pay all such emergency evacuation, ambulance, doctor, nurse, and/or hospital expenses.
- I also declare that I have read the **Personal Equipment List** for safe participation and will ensure the participant attends with ALL the items listed.

Signed: _____

(parent/guardian) Date: _____

ONLY COMPLETE THIS FORM IF YOUR SON / DAUGHTER HAS AN ASTHMA MANAGEMENT PLAN

Name of participant _____

This form must be completed by the participant's parent/guardian if the participant is a known asthma sufferer. This information is of vital importance in the event of an asthma attack as it will assist in the speedy provision of correct treatment.

Is preventative medication used regularly? yes no
If yes which one(s)? _____

Has a medical maintenance program been worked out with the asthmatic's doctor in order to reduce the frequency/severity of attacks? yes no

If yes, what is the normal maintenance program followed by the asthmatic?

Is the asthmatic on any reliever medications? yes no
If so which one(s)? _____

What is the medication and treatment to be used during an attack?
Please make sure the student carries this with them while on camp.

Does the asthmatic always carry their medication(s) with them? yes no

Does the asthmatic own/use a Peak Flow Meter? yes no
If yes, what would:

a) indicate that they would require medication? _____

b) indicate that they require medical attention? _____

List any known asthmatic trigger factor(s) experienced by the asthmatic

Has the asthmatic been admitted to hospital due to asthma in the last 12 months? yes no

Does the asthmatic suffer sudden asthma attacks requiring hospitalisation? yes no
I understand that my son/daughter's involvement in this Inter-Action program may mean that he or she is remote from immediate medical help (from an hr to a full day dependent on the program). In consultation with the child's Medical Practitioner I have provided Inter-Action with enough written information to deal appropriately with an asthma 'attack'.

Extra information attached yes no

Signed (parent) _____

Date _____

ONLY COMPLETE THIS FORM IF YOUR SON / DAUGHTER HAS AN ALLERGIC REACTION MANAGEMENT PLAN

Name of Participant: _____

Please complete this form if your child has ever suffered an allergic reaction to:

- insect bites food groups or additives plant pollens
 toxins (eg spider, snake bites) detergents or cleaning agents any other triggers

What is the participant allergic to:

What are the signs and symptoms of the participant's reaction:

Has the participant at any time suffered from:

- a localised reaction** (any rash, itching, swelling at the site the poison has entered)
 a systemic reaction (any rash, itching, swelling away from the site the poison has entered)
 an anaphylactic reaction (severe breathing problems, swelling of the body, emergency situation)

What medication does the participant take (if any) for prevention against allergic reaction?

All medication for the treatment of this reaction must be brought on the program by the participant and be noted on the medical form.

What treatment is followed for the participant if an allergic reaction occurs?

FIVE VITAL QUESTIONS

1. Does the person suffer a systemic reaction to their allergy? yes no
2. Does the person suffer an anaphylactic reaction to their allergy? yes no
3. Is there a family history of anaphylaxis? yes no
4. Has the person ever been hospitalised due to an allergic reaction? yes no
5. Is adrenaline (eg adrelaline injection, medi-epihaler, epi-pen) administered to the person when they suffer from an allergic reaction? yes no

If **yes** has been answered to any one of these five vital questions, please read and sign below:

I understand that my son/daughter's involvement in this Inter-Action program may mean that he or she is remote from immediate medical help (an hour to a full day dependent on the program). In consultation with the child's Medical Practitioner I have provided Inter-Action with enough written information to deal appropriately with an allergic condition.

Extra information attached yes no

Signed (parent) _____ Date _____