Outdoor School – Bogong
Parent Consent Form — Valid 2016/17

Student’s Full Name: __________________________________________________________

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I agree to my child using the internet and computer network at Bogong in accordance with the same internet student users agreement that applies at their current school.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is English your child’s main language?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child been away from home before?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I authorise the teacher in charge to administer paracetamol as per the Outdoor School protocol.</td>
<td></td>
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</tr>
</tbody>
</table>

I agree to my child’s attendance at the Outdoor School - Bogong and to his/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 liaison with the School Principal for his/her return.

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 Department 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 2016/2017
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 ___________________________

Full Name: ___________________________ Date of Birth: _______________ Male/Female

Parent/Guardian/Contact Person’s Full Name: Parent

Parent details are required if Medicare is used.

D.O.B. ___________________________

Address: ___________________________

Home Phone: __________ Work Phone: __________ Mobile Phone: __________

Home Email Address: ___________________________

Name & Address of Family Doctor: ___________________________

Medicare No: ___________________________ Valid to: _____/_____

Child’s Number (eg. 2, 3, 4): __________

Medical/Hospital Insurance Fund: ___________________________________________

Member No: ___________________________

Ambulance Subscriber: Yes — No

If yes, member number:

<table>
<thead>
<tr>
<th>Tick</th>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dietary Requirements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dizzy Spells/Blackouts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fits Of Any Type</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hay Fever</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heart Condition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Migraines</td>
<td></td>
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<tr>
<td></td>
<td>Physical Difficulties</td>
<td></td>
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<tr>
<td></td>
<td>Previous Injuries</td>
<td></td>
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<tr>
<td></td>
<td>Sleepwalking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Travel Sickness</td>
<td></td>
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<tr>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Anaphylaxis</th>
<th>If ticked you MUST attach the appropriate completed Anaphylaxis Action Plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible person is:</td>
<td>Please state below who will be responsible for carrying the Epipen/Anapen?</td>
</tr>
<tr>
<td>Allergies</td>
<td>If ticked you MUST complete and attach the Allergic Reactions Action Plan.</td>
</tr>
<tr>
<td>Asthma</td>
<td>If ticked you MUST complete and attach the Asthma Action Plan.</td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medication</th>
<th>Dosage</th>
<th>When given &amp; instructions.</th>
</tr>
</thead>
</table>

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+)

Signature of Parent/Guardian: ___________________________ Date: ___________________________

DET requires this consent to be signed for all students and teachers attending school excursions.
Asthma Care Plan for Schools – Outdoor School – Bogong

Staff are trained in asthma first aid (see below) and can provide routine asthma medication as authorised in this care plan.

1. Sit the person upright.
   a. Be calm and reassuring.
   b. Do not leave them alone.
2. Give 4 puffs of blue reliever puffer medication.
   a. Use a spacer if there is one.
   b. Shake puffer.
   c. Put 1 puff into spacer.
   d. Take 4 breaths from spacer.
   
   *Repeat until 4 puffs have been taken.*

   *Remember: Shake, 1 puff, 4 breaths.*
3. Wait 4 minutes.
   a. If there is no improvement, give 4 more puffs as above.
4. If there is still no improvement call emergency assistance (DIAL 000).
   a. Say ‘ambulance’ and that someone is having an asthma attack.
   b. Keep giving 4 puffs every 4 minutes until emergency assistance arrive.

If calling triple zero (000) does not work on your mobile phone, try 112.

Please write down anything different this student might need if they have an asthma attack.

Student’s Name: ___________________________ Date of Birth: ___________________________

**Daily Asthma Management**

<table>
<thead>
<tr>
<th>This student’s usual asthma signs.</th>
<th>Frequency and severity.</th>
<th>Known triggers for this student’s asthma (e.g. exercise, colds/flu, smoke) – please detail:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td>Daily/most days.</td>
<td></td>
</tr>
<tr>
<td>Wheeze</td>
<td>Frequently (more than 5 x per year)</td>
<td></td>
</tr>
<tr>
<td>Difficulty breathing</td>
<td>Occasionally (less than 5 x per year)</td>
<td></td>
</tr>
<tr>
<td>Other (please describe below)</td>
<td>Other (please describe below)</td>
<td></td>
</tr>
</tbody>
</table>

Does this student usually tell an adult if he/she is having trouble breathing.   [ ] Yes  [ ] No
Does this student need help to take asthma medication?          [ ] Yes  [ ] No
Does this student use a mask with a spacer?               [ ] Yes  [ ] No
Does this student need their blue reliever puffer medication before exercise? [ ] Yes  [ ] No

**Medication Plan**

If this student needs asthma medication, please detail below and make sure the medication and spacer/mask are supplied to staff.

<table>
<thead>
<tr>
<th>Name of medication and colour.</th>
<th>Does/number of puffs.</th>
<th>Time required.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Name of doctor: ___________________________ Phone: ___________________________

Doctor’s Signature: ___________________________ Date: ___________________________

**Parent/Guardian**

I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to staff and emergency medical personnel. I will notify the staff in writing if there are any changes to these instructions. I understand staff will seek emergency medical help as needed and that I am responsible for payment of any emergency medical costs.

Name (please print): ___________________________ Signature: ___________________________ Date: ___________________________
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
**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.
**ACTION PLAN FOR Anaphylaxis**

For use with Anapen® Adrenaline AutoInjectors

**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 Anapen® 300 or Anapen® 150
- 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 Anapen® 300 or Anapen® 150
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.

Anapen® 300 is generally prescribed for adults and children over 5 years.  
Anapen® 150 is generally prescribed for children aged 1-5 years.  
*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

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