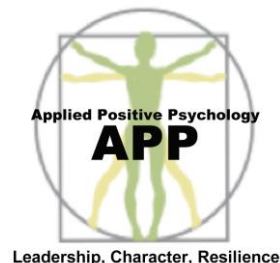




Applied Positive Psychology

Year 10 Camp
Mon 11 to Thurs 14 October 2021



CONSENT AND RELEVANT MEDICAL INFORMATION

Privacy Statement
 The Department of Education is collecting the personal information in this form in order to:
 - obtain consent for the named child/student to participate in the named off-site activity;
 - help coordinate the off-site activity;
 - respond to any injury or medical condition that may arise during or as a result of the off-site activity;
 and
 - update school records where necessary.
 The information will only be accessed by authorised departmental staff. The information will not be disclosed to any other person or agency unless we have your consent or we are required or authorised by law to do so e.g. in compliance with relevant [Queensland Chief Health Officer's Directions](#).

STUDENT

Student's First Name		Student's Surname	
Date of Birth		Medicare No.	

EMERGENCY CONTACTS

Emergency Contact 1 (Name)		Relationship	
Home Phone No.		Work Phone	Mobile

Emergency Contact 2 (Name)		Relationship	
Home Phone No.		Work Phone	Mobile

RELEVANT STUDENT'S MEDICAL HISTORY

STUDENT'S NAME -

When was your last Tetanus Booster

(If over 10 years you are advised to arrange a booster before the camp)

Have you ever suffered from	YES	Comments
Asthma*	<input type="checkbox"/>	
Allergies*	<input type="checkbox"/>	
Diabetes*	<input type="checkbox"/>	
Epilepsy*	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	
Blood Pressure	<input type="checkbox"/>	
Recent Illness/Injury/Operation	<input type="checkbox"/>	
Sleep Walking	<input type="checkbox"/>	
Migraines	<input type="checkbox"/>	
Behavioural Issues e.g. ADD	<input type="checkbox"/>	
Disabilities	<input type="checkbox"/>	
Current Infectious Diseases E.g. <i>Colds, Viruses, measles, chicken pox, Head Lice, Hepatitis A, B, C Blood disorders</i>	<input type="checkbox"/>	
Any issues or concerns we should be aware of?	<input type="checkbox"/>	
Swimming Ability (circle)	<input type="checkbox"/> Non-Swimmer <input type="checkbox"/> Weak <input type="checkbox"/> Okay <input type="checkbox"/> Strong	
Special Dietary Needs		

** If you have answered Yes for a condition please provide an Emergency Action Plan if you have one. For this conditions Asthma and Allergies, please complete the respective form available on the school website or at the school office*

MEDICINES

Is your child currently taking medication? Yes No If yes, please note the following:

In general, medication may be carried by a student, but please ensure the medication is clearly labelled with your child's name and dosage requirements. For security, some medications may need to be handed to the accompanying teacher before departure on Camp. Please advise of medications below.

Drug Name, dosage, frequency, any instructions
1
2
3

If you have any further details that may assist us in taking care of your child during this program, please attach a separate note to this form. You may also wish to discuss any concerns with us personally.

Further information is attached to this form: Yes No

RETURN TO: Head of APP or School Administration Office
 Faculty of Applied Positive Psychology
 Phone: 07 3511 3888 Fax: 07 3511 3800

DECLARATION

Activity risks and insurance

Please note that the Department of Education does not have personal accident insurance cover for children/students. If your child is injured as a result of an accident or incident while participating in the activity, all costs associated with the injury, including medical costs are the responsibility of the parent/carer. Some incidental medical costs may be covered by Medicare. If you have private health insurance, some costs may also be covered by your provider. Any other costs must be covered by parents/carers. It is up to all parents/carers to decide the type/s and level of private insurance they wish to arrange to cover their child. Please take this into consideration in deciding whether or not to allow the child/student to participate in this activity.

Consent

I acknowledge that through participation in the program activities, as organised by The Gap State High School, that in addition to usual risks inherent, certain other risks and dangers may be encountered, which may include (but not limited to): remoteness from normal medical services, moderate physical exertion for which my child may not be prepared; weather extremes subject to sudden unexpected change; evacuation difficulties if my child is disabled.

My child willingly agrees to follow and comply fully with the safety standards and procedures as described by school staff.

I acknowledge that **should it be required that my child return to school or home from camp I am responsible for their transportation.**

I acknowledge that on first day of the camp, **I will not send my child on camp if they are:**

- Experiencing symptoms of coronavirus (e.g. cold or flu like symptoms)
- Have a temperature
- Have been in contact with someone that is confirmed to have CoVID-19
- Have returned from overseas in the past 14 days.

If my child exhibits CoVID-19 like symptoms while on camp they will be quarantined and they will be required to be picked up by a care giver.

By signing this form, I agree that:

- **I have read all of the information contained in this form** in relation to the activity (including any attached material)
- **I am aware that the department does not have personal accident insurance cover for students**
- I will pay to the school the costs detailed in the attached letter for the child/student's participation in the activity.
- **I agree to and understand the refund policy** as it applies to this excursion (see attached letter)
- **In the event of an accident or illness, school staff may obtain or administer any medical assistance or treatment** the child/student may reasonably require, including contacting their doctor
- **I accept liability for all reasonable costs incurred** by the department in obtaining such medical assistance or treatment (including any transportation costs) and undertake to reimburse the department the full amount of those costs
- I have provided the school with **all relevant details of the student's medical or physical needs** on registration /enrolment and where relevant, **have updated this information**
- I give consent for a teacher to provide **paracetamol** to my child if required
- I give consent for student contact information to be shared in relation to this activity in compliance with relevant [Queensland Chief Health Officer's Directions](#).
- I give consent for sharing of relevant information contained herein should it be necessary to prevent harm or loss.
- **I give consent for** _____ **to participate in the Year 10 Camp activity on 11-14 October 2021.**

Parent/Carer name:

Parent/Carer signature:

Date:



Y10 CAMP 2021

PAYMENT ADVICE FORM

Due by 8 September 2021

Please send this form back to advise us of the payment method you have used for this camp.
 *** Please ensure you provide the RECEIPT NUMBER below.

Y10 Camp		Y10 CAMP PAYMENT
Student Name:		
Payment Amount: See above	\$ 440.00	
	<p>DETE Preferred Payment Method - BPoint</p> <p>Please use the CRN (Customer Reference Number) located on the bottom left hand side of your Invoice. Payment can be made through the Payment Portal. This is a secure site and receipts are issued immediately. Our records are updated within 24 hours. Copies of invoices and receipts are available in your QParents Portal. Payments can also be made in QParents.</p> <p>BPoint Receipt Number:</p>	
	<p>By Phone with a Credit/Debit Card</p> <p>Please phone 1300 BPoint - 1300 631 073. When making a payment please have your invoice ready as you will need your CRN (Customer Reference Number) and Invoice Number.</p> <p>Your Receipt Number:</p>	
	<p>Direct Banking Payment can be made to</p> <p>BSB. 064 174 Acct No. 00090008</p> <p>Ref: <i>Surname</i> Camp</p> <p>Your Receipt Number:</p>	
	<p>In Person at The Gap State High School</p> <p>Payment can be made by EFTPOS at the school office. Office Hours are Monday to Friday, 8:00am to 2:00pm on school days.</p>	



Allergy/Medical Action Plan

Y10 Camp 2021

To help ensure the safety of your son/daughter it is essential that if they have a serious allergy or medical condition this form is completed accurately and with as much detail as possible. All information will remain confidential to teachers and any relevant care and response personnel. You could get your doctor to fill in this **Action Plan**, or you may send us a copy of your existing Action Plan.

Student's Name:	Doctor's Name and Contact Details

Emergency Contact		Phone Nr		Relationship	
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DESCRIBE THE CONDITION	
Is the Condition Life Threatening?	Yes No
What triggers the condition?	
What Signs and Symptoms should we watch for?	

WHAT STEPS SHOULD WE TAKE TO RELIEVE THE CONDITION?	
1	
2	
3	
4	
5	
Other Instructions (e.g. triggers to avoid, other medicines etc.)	

DANGER SIGNS	In an emergency we will do appropriate first aid and call 000
Anything Else you want us to know?	

Parent/Guardian Name:

Signature:

Date:



Asthma Action Plan – Y10 Camp 2021

To help ensure the safety of your son/daughter, it is essential that if they have an asthma condition, that this form is completed accurately and with as much detail as possible. All information will remain confidential to teachers and any relevant care and response personnel. You could get your doctor to complete this **Asthma Action Plan**, or you could send us your existing Asthma Action Plan.

Student's Name:	Doctor's Name and Contact Details

Emergency Contact		Phone Nr		Relationship	
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WHEN WELL		ASTHMA IS UNDER CONTROL (Almost no symptoms)			
Student always carries their reliever?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Student uses Spacer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Preventer is (name and Strength):					
Take Preventer		puffs/tablets		times per day	
Reliever is (name):					
Take Reliever		puffs	when symptoms occur like		
Other Instructions (e.g. triggers to avoid, other medicines etc)					

WHEN NOT WELL		ASTHMA IS GETTING WORSE Using more reliever than usual			
Keep taking Preventer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Student uses Spacer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Take Preventer		puffs/tablets		times per day	
Reliever is (name):					
Take Reliever		puffs	when symptoms occur like		
Other Instructions (e.g. triggers to avoid, other medicines etc)					

IF SYMPTOMS GET WORSE		Severe Asthma flare-up/attack. Difficulty breathing waking with symptoms			
Keep taking Preventer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Student uses Spacer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Take Preventer		Puffs		times per	
Keep taking Reliever					
Take Reliever		Puffs		times per	Student uses Spacer Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Instructions (e.g. triggers to avoid, other medicines etc)					
Anything Else you want us to know?					

Parent/Guardian Name: Signature:

Date: