Boyne Island Environmental Education Centre

Consent Form for a RESIDENTIAL VISIT to the Boyne Island Environmental Education Centre

Your child is to undertake an educational program of field studies at the Boyne Island Environmental Education Centre. Please provide the following information to enable the organisers of the program to provide better care for your child. During this visit, your child will participate in a variety of activities that may include initiative games, problem solving and trust activities, using virtual reality (VR) goggles, walking, bike riding, low ropes, high ropes, cooking, bush cooking or campfires, swimming, surf awareness & beach games, snorkelling, fishing, canoeing, boating, travelling on ferries, centre's boats and science activities to explore the local environment.

PRE-VISIT INFORMATION

The Boyne Island Environmental Education Centre is a residential educational facility operated by the Queensland Department of Education. It is staffed by teachers who are specially trained in outdoor activities. Queensland's outdoor and environmental education centres were established to provide unique opportunities to enhance the learning of your child. Although part of the Department of Education, these centres rely on fee-for-service to meet their operating costs.

Privacy Notice: The Department of Education (DoE) is collecting this information to enable program organisers to provide appropriate health care for your child if required. This information will only be accessed by authorised Departmental employees. Some of this information may be given to external health providers. In accordance with s.426 of the Education (General Provisions) Act 2006 (regarding student's personal information) and the Information Privacy Act 2009 (parent/carer's personal information) your information will not be disclosed to any other person or body unless you have given DoE permission or DoE is required or authorised by law to disclose the information.

Medical Notice: Staff will provide immediate first aid and contact an ambulance as required following the HLS-PR First Aid Policy. School staff will not administer any over-the-counter medication, including analgesics, homeopathic or prescribed medication unless a written request is provided from a parent/guardian, accompanied by written advice from a medical practitioner and with the medication in the original labelled container. Parent/s are requested to make arrangements with the teacher-in-charge for the safekeeping and handling of prescribed medications and equipment prior to the program. All medication will be administered according to the HLS-PR-009 Administration of routine and emergency medication policy.

Accident Insurance Notice: The Department of Education does not have personal accident insurance cover for students. It is the responsibility of the parent / guardian to ensure that the student is adequately covered for Medical, Hospital and Dental Insurance.

SCHOOL: **YEAR LEVEL:** **DATE(S) of VISIT:**

NAME: Family ..... **Given** ..... **Gender: M / F** **DOB:** .....

Parent's Full Name: .....

Home Address: .....

Medicare Details: Does student have their own Medicare card? **YES / NO**

If NO, please state Medicare Card holder's name (first name on card): .....

1. Medicare No: ..... 2. Number of Person: ( ) 3. Expiry Date: ...../.....

Additional health insurance company name: ..... Membership number: .....

Emergency Contact(s):

(1) Name: ..... Relationship: ..... Home #: ..... Mobile # :.....

(2) Name: ..... Relationship: ..... Home #: ..... Mobile # :.....

(3) Name: ..... Relationship: ..... Home #: ..... Mobile # :.....

Name of Family Doctor: Name of Practice: Telephone Number:

Custodial Issues

Are there any custodial issues that the Principal and/or program staff should be made aware of? **YES / NO**

If YES, please provide details in writing.

Use of copyright material, image, recording, or personal information

Please see State School Consent form and complete. As our site is an alternate educational campus, previous consent forms submitted to school upon enrolment do not suffice.

Fitness Advice

During your visit your child can participate in a number of strenuous physical activities which may increase the health and safety risks if suffering from:

- Any medical conditions that may be made worse by physical exertion. (For example heart disease, asthma, some lung complaints)
- Any medical condition that can result in loss of consciousness. (For example some forms of epilepsy and some diabetic conditions)
- Asthma
- Previous strenuous physical activity

Will the person's medical condition/impairment **compromise their capacity or ability to participate** in the identified activities? Please indicate **YES / NO**

If YES, please write details to assist program coordinators in supporting your child.

SWIMMING ABILITY: Competent / Not competent

Behaviour Management

Teachers may take disciplinary action they deem necessary to ensure the safety, well-being and successful conduct of the students as a group, or individually during the program/activity. I am aware this may include returning my child home for which I agree to pay any additional costs incurred as well as for any deliberate damage caused by my child.

Specific Learning Needs /Disabilities (physical disabilities/learning difficulties/behaviour challenges/ diverse backgrounds / Aboriginal & TSI)

Infections and Immunisations

Please indicate YES or NO to provide during the program?

If YES, please write details to assist program coordinators in supporting your child. Has your child:

Condition		Details
had an infectious disease recently?	YES NO	
been in contact with any infectious diseases for the past 4 weeks?	YES NO	
received a Tetanus Booster?	YES NO	Year of last booster injection
been immunised against Hepatitis B	YES NO	
been immunised?	YES NO	Please list vaccinations below

Individual and/or emergency health plan (IHP/EHP)

Does your child have a health condition requiring an individual and/or emergency health plan (IHP/EHP) or Action Plan?
If you answer YES to any of the following, your teacher will supply you with an emergency action plan form which you will be required to complete and return to the school.

Condition		Details including known triggers	TEACHER TASKS		
			IHP/EHP required?	IHP/EHP sent home?	IHP/EHP Attached?
Asthma/Other Respiratory Problems	YES NO		YES NO	YES NO	YES NO
Diabetes	YES NO		YES NO	YES NO	YES NO
Epilepsy/Seizures	YES NO	(eg. VR goggles)	YES NO	YES NO	YES NO
Severe Allergy **(Anaphylaxis)**	YES NO		YES NO	YES NO	YES NO
Medical Allergies (e.g. penicillin)	YES NO		YES NO	YES NO	YES NO
Food Allergies	YES NO		YES NO	YES NO	YES NO
Other Health Need requiring IHP/EHP	YES NO		YES NO	YES NO	YES NO

Physical Wellbeing

Heart Problems (e.g. Murmurs)	YES NO	Travel Sickness	YES NO
Blood Pressure	YES NO	Sinus or Hayfever	YES NO
Fits or Faints	YES NO	**Details**	
Recent Illness	YES NO	**Details**	
Recent operation	YES NO	**Details**	
Recent injury	YES NO	**Details**	

Mental Wellbeing

Sleepwalking	YES NO	Bed Wetting	YES NO
Phobias	YES NO	**Details:**	

Social Wellbeing

e.g. special dietary requirements (i.e. medical/religious reasons)

e.g. Is there any medical or psychological reason to prevent your child from participating in or to take any special precautions of the activities outlined.

Medication

Is your child presently taking tablets and/or other forms of prescribed medication? (Please circle) **YES / NO**
If YES, please complete Part C, the *Authority of Administer Medication*.

Medical Condition	Medication	Dosage	When to be taken

Parent/s are requested to make arrangements with the teacher-in-charge for the safekeeping and handling of prescribed medications and equipment prior to the program. All medication will be administered according to the HLS-PR-009 Administration of routine and emergency medication policy.

Other

Please provide any other information about your child which will enable the organisers of the program to provide better care for your child.

Insect Repellent

Based on advice from Queensland Health, personal insect repellents containing Picaridin or DEET are recommended to protect students from insect bites. Personal insect repellents should only be used according to the manufacturer's recommendations noted on the product. Queensland Health advises that anyone with known allergies to personal insect repellents should not use these products. Parents should check the manufacturer's recommendations before use. If you have any concerns regarding your child's use of insect repellents, you should consider seeking medical advice prior to giving consent

Consent

I _____, give consent for _____

to participate in the identified activities. **Yes / No**

I give consent for teachers/staff involved in the program to **use copyright material**, image, recording, or personal information. **Yes / No**

I give consent for teachers/staff involved in the program to take appropriate **disciplinary action** and agree to **pay any additional costs** incurred as well as for any deliberate damage caused by my child. **Yes / No**

I give consent for teachers/staff involved in the program to **provide basic first** aid if required. **Yes / No**

I give consent for my child to watch a **PG rated film** **Yes / No**

I give consent for my child to **travel in a government/centre vehicle** (if required) **Yes / No**

I give permission for my child to have **insect repellent applied**. **Yes / No**

I give permission for my child to have **sun screen applied**. **Yes / No**

I authorise for teachers/staff involved in the program to **administer medication** according to the HLS-PR-009 Administration of routine and emergency medication policy**.** **Yes / No**

I authorise the teacher-in-charge/Centre Principal to obtain **medical/dental assistance** which they deem necessary should an accident occur, and agree to **pay all the medical expenses,** including pharmaceutical supplies on behalf of the above student. **Yes / No**

I authorize qualified practitioners to administer **anesthetic** if such an eventuality arises. **Yes / No**

I authorise qualified practitioners to administer **blood transfusions**, if such an eventuality arises **Yes / No**

I understand that all reasonable attempts will be made to contact me in the event of any emergency.

***Signature of parent/guardian:** ..... **Print Name:** .....

***Signature of Participant:** ..... **Print Name:** .....

Date: .....

**__Note__: If the Individual is under 18 years of age, the Signatory must be a parent or guardian of the Individual/Participant. The Individual/Participant must also sign if he or she is under 18 __and__ able to give and understand the consent. If the Individual/Participant is 18 or older, the Signatory and the Individual/Participant will be the same person.*