

Year 7 camp!

Name: _____ Pastoral Care Group : _____

Do you want to go on the Year 7 camp?

- ◆ Wombaroo ◆ 3 days/2 nights ◆ Week 5/Term 1 2018
- ◆ Activities include: Initiative activities, flying fox, giant swing, vertical challenge, high ropes course, archery, bushwalking and raft building
 - ◆ All meals provided
 - ◆ Accommodation in cabins

YES? Then complete this camp packet

PACKET : Complete the 3 forms (4 if there is a severe medical concern) in this packet and return this packet to the front office by Friday 16th February, Wk 2 with payment (\$230 if deposit of \$100 has already been made or \$330 if paying in full).

Checklist (check each box so we know you're not missing anything ☺):

- Permission Form – with payment details (if you are in need of financial assistance please don't hesitate to call the front office on 61421690)
- Medical Form – please read carefully as certain sections require extra forms to be filled in, dependent upon the individual needs of your child/ward. If you tick 'Yes' for asthma, allergies, diabetes or epilepsy you must fill in the 'fitness to participate form' and have it signed off by a doctor.
- Swimming Form (this if for raft building, it is optional to go in the water)

Please email Natalie Ikin at: Natalie.ikin@ed.act.edu.au or phone the school directly and ask to be referred through to the PE faculty if you have any questions.

Year 7 camp

Permission/payment form

Full Cost: \$330

**\$230 owing if deposit has already been made
Due by Friday 16th February, Wk 2**

Camp is on: Wednesday 7th – Friday 9th March, 2018 (Week 5/Term 1)

Staff: Supervising Staff members: Fiona Bridges (Year 7 co-ordinator), Natalie Ikin (Year 7 culture and community co-ordinator), Sue Smith (SLC student services), 2 Year 7 PCG teachers, 10 Year 10 student leaders

Departing: from BHS on Wednesday 7th at 7.30 am

Arriving: back to BHS on Friday 9th by 4.00pm

Location: Wombaroo Adventure Centre, Mittagong

I hereby give permission for my son/daughter/ward (first and surname):

to participate in the Year 7 camp at Wombaroo: 7th – 9th March 2018.

I acknowledge the details listed above and give permission for the supervising staff to seek medical attention for my child should they believe it is necessary. I am aware that I will be responsible for any medical expenses incurred and that free ambulance transportation (should it be required) only applies within the Australian Capital Territory.

- I have completed all the additional **medical forms** as required by the Wombaroo Adventure Centre.
- I also understand and accept that **normal school rules** apply during the excursion. If it is necessary for my child to return home early following a breach of these rules, I will be responsible for all costs and will not be eligible for any refund of excursion costs.
- I am aware that staff members are not responsible for injuries or damage to property which may occur on an excursion where, in all circumstances, staff have not been negligent. I have warned my child of the risk to themselves, to others and to property, of impulsive, wilful or disobedient behaviour.
- I agree to my child travelling by private car, driven by a staff member, if the need arises.
- I also give permission for **photos to be taken** of my child during this excursion and if required to be published in the school newsletter or school assembly.



Belconnen High School

Caring for Students and Striving for Excellence



◆ Please list any specific dietary requirements: (example: lactose intolerant, halal, gluten free, vegan, vegetarian)

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: / / Emergency Contact: _____

PAYMENT FORM

Payment for my son/daughter/ward:

First Name:	Surname:	PCGroup:
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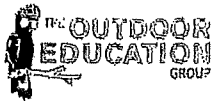
Parent/Guardian:	Date: / /	Emergency Contact:
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I enclose payment of \$..... Cash Cheque Credit Card Direct Debit go to:
www.blch.act.edu.au/payment

Payment may be debited to your Credit Card account by completing the authority form below: Visa MasterCard

Card No: | | | | | | | | | | | | | | | | Card Expiry Date: ____ / ____

Card Holder's Name: (BLOCK LETTERS)	Signed:
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Student Medical Form

The purpose of this form is to help us adequately prepare for your child's program. This information is confidential and students will not normally be excluded for medical reasons. (PLEASE COMPLETE IN FULL IN BLACK OR BLUE INK)

SCHOOL:..... Form / Class:.....

STUDENT NAME:..... D.O.B:...../...../..... Male Female

Parent or Guardian – Primary Emergency Contact:

Name:..... Relationship:.....

Phone: (Home)..... (Work):..... (Mobile):.....

Medicare No:.....	Doctor's Name:.....
Line #:..... Valid to:.....	Telephone:.....
MEDICAL HISTORY	Please tick Yes or No to all questions
Additional information: <i>Details regarding; seriousness, location, date, level of recovery, self-management strategies, required support</i>	

Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If YES, complete the 'Asthma Management Form'
Allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If YES, complete the 'Allergenic Reaction Management Form'
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If YES, attach current management / care plan. A 'Fitness to Participate' form signed by treating doctor will also be required.
Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If YES, a 'Fitness to Participate' form signed by treating doctor will also be required. Include information on triggers, last episode, medications.
Joint/Muscle/Skeletal issues	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Sight/Hearing Impairment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Any serious injuries/illness in the last 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Date & Nature of injury / illness</i>
Is your child currently on any medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Name of medication, dosage & requirements (e.g. with food, AM or PM)</i>
Other medical condition that may affect participation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Any physical health issue(s) that require attention or special support?</i>
Other: learning issues; psychological, emotional or behavioural issues?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Any concern(s) that require attention or specific support (e.g. management strategies for a successful experience)</i>

DIETARY Any special requirements?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Details to assist in menu planning (e.g. vegetarian, will eat fish; gluten-free, separate stove)</i>
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SWIMMING ABILITY My child can swim 50metres	<input type="checkbox"/> No	<input type="checkbox"/> with a struggle	<input type="checkbox"/> comfortably	<input type="checkbox"/> strongly
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Please note: OEG may require, after reviewing this information, that your child visits a doctor to gain approval to participate. This will be determined after this form is received by OEG and in consultation with you.
Office Use Only:

I declare that the information which I have provided on this form is complete and correct and that I will notify the school if any changes occur. I authorise the teacher or any employee of the Outdoor Education Group who is with my child, to give consent where it is impractical to communicate with me, and agree to my child receiving such medical or surgical treatment as may be deemed necessary. I give permission for OEG to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment of my child.
I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per the Privacy Policy documented on our website: (oeg.org.au).

Name:..... Signature:..... Date:.....

Photograph Consent: I consent to my child being photographed and/or visual images of my child being taken during activities, for use in OEG publications, on the OEG website, or for publicity purposes without acknowledgment and without being entitled to any remuneration or compensation. (Please strike out this sentence if you do not consent)

Student Evaluation Consent: I give consent for my child to complete the pre and post program course evaluation survey as part of the Outdoor Education Group continuous improvement process. Survey available at oeg.org.au. (Strike out this sentence if you do not consent)



Allergenic Reaction Management Form

Confidential

If necessary, seek the advice of your doctor when completing this form.

A DOUBLE DOSE OF ALL MEDICATION REQUIRED FOR THE PARTICIPANT'S ALLERGIC REACTION, MUST BE BROUGHT ON THE COURSE AND NOTED ON THE MEDICAL FORM. E.G. (if Epi-pens or any other type of Auto Injector is required 2 x must be supplied and brought to camp).

Student Name:

Name of doctor treating the student for this condition:

Doctor's Contact Phone Number:

1. What is the student allergic to?

Bites: Foods: Medications: Stings: Other:

Please Specify (e.g. Alex is allergic to penicillin and sulphur-based medications):

2. What are signs and symptoms of the person's reaction?

- Low** - a localised reaction (rash, itching, swelling at the site the poison/irritant enters)
- Moderate** - a systemic reaction (rash, itching, swelling away from the site that poison/irritant enters)
- Severe** - an anaphylactic reaction (severe breathing problem, total body swell, emergency situation) -
Note: An ASCIA Anaphylaxis Action Plan AND Fitness to Participate Form is required

Please give details:

3. What medication does the participant take (if any) for their allergic reaction?

4. Medication and treatment to be used during emergency situations:

"KEY QUESTIONS"

- | | | | | | |
|---|--|----|--------------------------|-----|--------------------------|
| 5 | Has the participant required hospitalisation due to allergies in the past 12 months? | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> |
| 6 | Has the participant suffered a systemic or an anaphylactic reaction (see question 2 for definition), to their allergy when triggered in the last 10 years? | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> |
| 7 | Does the person take, or has the person been prescribed, adrenaline (Epi-pen or similar), when suffering an allergic reaction? | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> |

IMPORTANT NOTES:

If any of the "KEY QUESTIONS" 5, 6 or 7 above are answered "Yes", the decision for the participant to attend rests with their Doctor. A "Fitness to Participate" form must be completed by the Doctor (attached). Please bring this form to the Doctor with you.

The Fitness to Participate form should be attached to the medical and asthma management forms and returned to school.

I declare that the information provided on this form is complete and correct. I further declare that if my child (or I for adults) is unable to self administer supplied medication, I give permission for trained OEG staff to administer the supplied emergency medication. I give permission for OEG to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment of my child (or myself for adults). I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per Privacy Policy documented on our website: (oeg.org.au).

Name: _____ Signature: _____ Date: _____



Asthma Management Form

Confidential

Participant's Name:

Name of doctor treating the participant for this condition:

Doctor's Contact Phone Number:

1) USUAL ASTHMA ACTION PLAN

Usual signs of participant's asthma:

- Wheeze Tight Chest Cough Difficulty breathing Difficulty talking Other _____

Signs participant's asthma is getting worse:

- Wheeze Tight Chest Cough Difficulty breathing Difficulty talking Other _____

Participant's Asthma Triggers:

- Cold/flu Exercise Smoke Pollens Dust Other (please describe) _____

ASTHMA MEDICATION REQUIREMENTS (Including relievers, preventers, symptom controllers, combination)

Name of Medication (e.g. Ventolin, Flixotide)	Method (e.g. puffer & spacer, turbuhaler)	When and how much? (e.g. 1 puff in morning and night, before exercise)

Does the participant need assistance taking their medication? Yes No If yes, how? _____

Any other information that will assist with the asthma management of the participant while on camp
 e.g. peak expiratory flow, night time asthma or recent attacks

2) ASTHMA FIRST AID PLAN (Please tick preferred Asthma First Aid Plan)

School Asthma Policy for Asthma First Aid

Step 1. Sit the person upright

- Be calm and reassuring
- Do not leave them alone.

Step 2. Give medication

- Shake the blue reliever puffer
- Use a spacer if you have one
- Give 4 separate puffs into a spacer
- Take 4 breaths from the spacer after each puff

*You can use a Bricanyl Turbuhaler if you do not have access to a puffer and spacer.
 Giving blue reliever medication to someone who doesn't have asthma is unlikely to harm them.

Step 3. Wait 4 minutes

- If there is no improvement, repeat steps 2.

Step 4 If there is still no improvement call emergency assistance (**DIAL 000**).

- Tell the operator the person is having an asthma attack
- Keep giving 4 puffs every 4 minutes while you wait for emergency assistance

Call emergency assistance immediately (DIAL 000) if the person's asthma suddenly becomes worse.

OR

Participant's Asthma First Aid Plan (if different from above)

- In the event of an asthma attack, I agree to the participant receiving the treatment described above.
- Notify in writing if there are any changes to these instructions.

3) KEY QUESTIONS

a.	Has asthma interfered with participation in physical exercise within the past 12 months	NO	[]	YES	[]
b.	Has the participant required hospitalization due to asthma in the past 12 months?	NO	[]	YES	[]
c.	Has the participant been on oral cortisone for asthma within the past 12 months (e.g. Prednisone, Cortisone, etc)?	NO	[]	YES	[]
d.	Has the participant suffered sudden severe asthma attacks requiring hospitalisation within the past 12 months?	NO	[]	YES	[]
e.	Does the participant require the use of a nebulising pump as a part of your regular or emergency asthma treatment?	NO	[]	YES	[]

4) IMPORTANT NOTES

If any of the "KEY QUESTIONS" a, b, c, d, or e above are answered "Yes", the decision for the participant to attend rests with their Doctor. A "Fitness to Participate" form must be completed by the Doctor (attached). Please bring this form to the Doctor with you.

The Fitness to Participate form should be attached to the medical and asthma management forms and returned to school.

I declare that the information provided on this form is complete and correct and that I will notify the school if any changes occur. I further declare that if my child (or I for adults) is unable to self administer supplied medication, I give permission for trained OEG staff to administer the supplied emergency medication. I give permission for OEG to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment of my child (or myself for adults). I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per Privacy Policy documented on our website: (oeg.org.au).

Name: _____ Signature: _____ Date: _____



The Outdoor Education Group

Fitness to Participate Form

Confidential

School Name: _____ Year Level: _____

Name of Participant: _____ D.O.B. _____

Specific Medical Condition: (e.g. Asthma, Allergies) _____

Notes to treating Doctor

This patient is scheduled to participate in an Outdoor Education program and has self-identified a pre-existing medical condition on their medical form.

Outdoor Education programs with OEG are centred in a 'semi-wilderness' setting, meaning that professional medical care may be from 1 to 6 hours away. All programs include regular physical exercise and activities may include bushwalking (with packs), camping, cycling, rock climbing or canoeing. We operate in all weather conditions.

(Should you require any further information on the program, please contact us at (02) 4878 5393 and quote the name of the client organisation and year level listed at the top of this page)

OEG staff hold a Wilderness First Aid qualification (minimum of 7 days training). This training is based on assessing and treating a patient in a remote or wilderness setting. For more information see <http://www.wms.org/>

Doctor to complete:

Based on this information above and the patient's condition, we ask that you decide on this person's suitability to participate in the upcoming program. If approved, please include specific treatment protocols to follow in the event of an emergency.

Do you approve this participant attending an Outdoor Education program, based on their current medical condition, coupled with the demands of the program?

Yes

No

What treatment protocol are you willing to authorize for this patient in the case of a medical emergency, in a remote location (i.e. one or more hours away from medical care)?

What should the OEG staff managing this participant in the field be informed/aware of, in regards to the particular situation for this patient? What are the recommended parameters for participation in the activities?

Name of Doctor: _____ Phone: _____

Signature of Doctor: _____ Date: _____

I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per Privacy Policy documented on our website: (oeg.org.au)

Swim Form

Permission for Aquatic Activities:

◆ Raft building – students will be required to build a raft on land and then test that land in a still water dam/lake. Going into the water is optional and life jackets will be available.

To help ensure the safety of your child, please provide the following information:

Name of student (first and last name): _____ PCG:

My child can swim: Yes No

If you answered 'No', your child can still attend, it is optional to go into the water.

If you answered 'Yes' to the question above, select the distance your child can swim:

10m 25m 50m 100m

Describe in detail your child's swimming ability, e.g. water confidence, swimming strength, distance (swimming continuously) and ability to tread water:

List any special requirements necessary for your child to participate in the water activities:

Did your child complete the swim test at the BHS Swimming Carnival earlier this year and receive either a blue or yellow band Yes No Don't remember/not sure

I agree to my child taking part in the swimming/aquatic activities associated with this excursion.

Name of Parent / Carer: (please print) _____

Signature: _____ Date: / /



YOUR GEAR LIST

ESSENTIAL ITEMS – ONSITE (these items are required while you are on site at Wombaroo)		
ITEM:	NOTES:	PACKED:
2 x T-shirts	Offer best sun protection & singlets aren't comfortable when wearing harnesses	<input type="checkbox"/>
1 x Long sleeved shirt	Long sleeves are required for some activities e.g. Archery	<input type="checkbox"/>
2 x Warm jumpers	Wool or polarfleece will stay warm if wet.	<input type="checkbox"/>
2 x Shorts	Mid-thigh or longer because of sun exposure and harnesses.	<input type="checkbox"/>
1 x Long pants	Lightweight is good. Jeans are not great for activities.	<input type="checkbox"/>
Underwear		<input type="checkbox"/>
Socks	1 pair per day, plus one extra. Thick woollen socks are great when hiking.	<input type="checkbox"/>
Swimmers	Boardies and a rash top will give best sun protection. No bikinis please.	<input type="checkbox"/>
Sleepwear		<input type="checkbox"/>
Sunglasses		<input type="checkbox"/>
Beanie	It can get chilly at night	<input type="checkbox"/>
Sturdy enclosed shoes	Training shoes are fine for general wear. Something more robust with ankle support if hiking	<input type="checkbox"/>
Shoes (spare)	Enclosed shoes for water activities that you don't mind getting wet. Not crocs or thongs please.	<input type="checkbox"/>
Pillow and Pillow Case		<input type="checkbox"/>
Sleeping bag or Dooner	A three season bag should be appropriate at any time of year.	<input type="checkbox"/>
Towel	A minimum of two if participating in watersports activities	<input type="checkbox"/>
Toiletries	Toothbrush, toothpaste, brush/comb, personal hygiene, deodorant - non aerosol is preferred.	<input type="checkbox"/>
Day Pack / Small Bag	To carry your water bottle, jacket, camera etc.	<input type="checkbox"/>
Rain Jacket	Waterproof with a hood.	<input type="checkbox"/>
Small Torch	Spare batteries might be useful.	<input type="checkbox"/>
Garbage Bags	Handy for putting wet shoes/clothes in.	<input type="checkbox"/>
Sunscreen	30+ SPF	<input type="checkbox"/>
Sunhat	Wide brim please.	<input type="checkbox"/>
Sunglasses		<input type="checkbox"/>
Water Bottle	A 2L bottle is best (an old plastic bottle is fine!)	<input type="checkbox"/>
Insect Repellant	Non aerosol is preferred.	<input type="checkbox"/>
Pen/pencil/notebook		<input type="checkbox"/>
Camera	Optional	<input type="checkbox"/>
Medication	You must bring at least two doses of any prescribed medication.	<input type="checkbox"/>

ITEMS NOT TO BRING - We cannot offer secure storage for the following items		
Jewellery	Mobile Phones	Ipods & similar