

Please complete and return to the School Office by Thursday 8 August 2019.



# PARENT CONSENT FORM Camps

**OFFICE USE ONLY**

Cost: \$180.00 Per Student

Paid: YES / NO

Date: / /

**Please Note:**

1. Online camp payments are preferred and can be made via the Xplor portal at the following link: [stpaulsips.xportal.myxplor.com](http://stpaulsips.xportal.myxplor.com) or cash payments will be accepted at the School Office.

Please also note that if camp payments **are not received by Thursday 8 August 2019** or by prior arrangement with the Business Office, then the student will not be allowed to attend and will remain at school under teacher supervision.

2. It is a legal requirement that Parent Consent/Medical Forms be returned prior to the camp. It is the school's requirement that this be returned by **Thursday 8 August 2019**. If your child's form is not received by this date, they will not be able to attend the camp.

I/we, \_\_\_\_\_ as parent/carers of  
*Your First Name and Surname*

\_\_\_\_\_  
*Child's First Name and Surname*

\_\_\_\_\_  
*Class*

give my/our consent for him/her to attend the **Year 3 Camp to YMCA North Pine, Petrie to be held from Thursday 15 August and returning back to the school on Friday 16 August 2019.**

I/we accept that the teachers and instructors will take appropriate disciplinary action in an attempt to ensure the safety, well-being, and successful conduct of the students who participate in the activities associated with the camp.

In the event of any illness or accident, I/we authorise the obtaining of such medical assistance as my child may require. In the event of any medical emergency during the camp, I/we appoint the supervising teacher-in-charge as our agent, with the right to arrange ambulance evacuation and medical treatment, if deemed necessary, and we cannot immediately be contacted. Any such duly qualified doctor who treats our child in any emergency life-or-death situation:

**Strike out which does not apply below and SIGN the action you wish to be taken.**

- a) Has my/our consent to undertake life-saving surgery, including if necessary, the administration of anaesthetic and/or blood transfusions.

Parent Signature: \_\_\_\_\_

**OR**

- b) Has my/our consent to take the following alternative action in a life-or-death emergency situation, because of our religious or other objections to blood transfusions or anaesthetics.

\_\_\_\_\_  
\_\_\_\_\_

Parent Signature: \_\_\_\_\_

I/we also accept the responsibility for payment of any expenses thus incurred which exceed the limit imposed by the school's insurance policy (student insurance details are available from the office).

**If your child requires medication whilst on the excursion, please provide the medication with a Pharmacy Label (Patient Name, Dosage, Doctor's Name) in a clearly labelled container or quick seal bag with documentation stating dosage and frequency and hand it to the teacher on the morning of the excursion.**

I/we include the completed medical information section (over the page) about my/our child to assist those who are organising the excursion, and for reference in any medical emergency. I/we will notify the school of any changes to medical conditions during the duration of the excursion.

Signed: \_\_\_\_\_  
*Parent / Person with Legal Responsibility for the Child*

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**(Continued Over Page)**

Emergency Contact Telephone Numbers: \_\_\_\_\_

(Please include name of contact) \_\_\_\_\_

Please tick if your child suffers any of the following:

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Fits of Any Type | <input type="checkbox"/> Heart Condition           |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Dizzy Spells     | <input type="checkbox"/> Sleepwalking              |
| <input type="checkbox"/> Blackouts   | <input type="checkbox"/> Migraines        | <input type="checkbox"/> Travel or Motion Sickness |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Other _____      |  |

Does your child have any other medical condition or disability which may affect his or her participation in this camp? **YES / NO**

*\*If YES, please give details.*

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Is your child on any prescribed medication/s which would be required to be continued during this camp? **YES / NO**

*\*If YES, please give details.*

***If your child requires medication, including PARACETAMOL, whilst on the camp, please provide the medication with the Pharmacy Label (Patient Name, Dosage, Doctor's Name) in a clearly labelled container or quick seal bag with documentation stating dosage and frequency and hand it to your child's classroom teacher on the morning of the camp.***

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Does your child have any allergies or sensitivities (e.g. insect bites, food)? **YES / NO**

*\*If YES, please give details.*

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**"STOP ITCH" MEDICATION**

Permission to administer Stop Itch as required (according to instructions on packaging)

**YES / NO**

Is your child **able** to swim?

**YES / NO**

Does your child have a fear of the water?

**YES / NO**

Do you give consent for photos/video of your child to be taken by the teachers/staff on this camp?

**YES / NO**

Is there any other information you would like to give which, in your view, may assist the school in the care and safety of your child during this camp?

**YES / NO**

*\*If YES, please give details.*

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