It is important that this form is completed by all parents and adults taking part in this Education Outside the Classroom (EOTC) event. The information will enable the school to ensure that optimal staffing levels are provided, the specific needs of participants are met, and the educational value and safety of events is maximized. Details on these forms will remain confidential to school staff, contractors and volunteers associated with supervising activities on the EOTC event. Please provide us with information that is accurate and complete.

|  |
| --- |
| **Parent/Volunteer to complete** |
| **Parent / Volunteer** |  | **Learning Advisor** **In Charge** |  |
| **EOTC Trip** **Activity/ Event** |  | **Activity/ Trip date(s)** |  |
| **Address** |  | **Home** **Phone** |  |
| **Cell** **Phone** |  |
| **Email** |  | **Work** **Phone** |  |
| I have a **Current First Aid Certificate**:  | No  Yes  Basic/ Workplace First Aid  Comprehensive First Aid  PHEC  |

|  |  |
| --- | --- |
| I hold a **current Full Drivers License**:  | No  Yes  Class: Car  Passenger Service  Taxi  Bus Other ………………… |
| **Passengers**: I am willing to: | Transport students with my own vehicle  Transport students with a van with (school or hire)   |
| **Vehicle Road Worthiness**: | The Vehicle is insured:  Registered  | The Vehicle is road worthy and has a current WOF / COF  |
| **Passenger Safety**:  | Each passenger has and will use a seat belt  |

|  |
| --- |
|  |
| **Health Information**: A Health Profile form has been filled out for myself this year  | Date of birth |  |
| **NO**  | Please complete a Health Profile form and return to Learning Advisor in Charge asap |
| **YES**  | Health Information provided previously this year is correct  | Yes  | No  |
| Updated Health Information: Please add any minor changes to your health status that we need to be aware of.  |

|  |  |
| --- | --- |
| Emergency contact details | **PLEASE INDICATE THE PEOPLE TO BE CONTACTED IN THE EVENT OF AN EMERGENCY** |
| **Emergency Contact #1 NAME:** |  | **Home Phone:**  |  |
| **Their Relationship to you:** |  | **Cell/ Work:** |  |

|  |  |  |
| --- | --- | --- |
| **I** have filled out a Volunteer Information form (EOTC 6) previously this year | Yes  | No  |
| I have had a Police Vetting Check previously  | Yes  | No  |
| If NO, please complete THE AUTHORISATION TO DISCLOSE below | If YES, are the details provided still correct? | Yes  | No  |

**Acknowledgment of Risk Consent: To be read and signed by Volunteer / Adult Participant**

I have read the information provided about the event and agree to taking part. I consent to any emergency treatment required by myself during the course of the event should it be required. I confirm that I am in good health and I consider myself fit to participate in/oversee supervised water-based activities.

I understand that there are risks associated with involvement in school EOTC events and that these risks cannot be completely eliminated. I understand that the school will identify any foreseeable risks or hazards and implement correct management procedures to eliminate, isolate, or minimise those hazards. Where relevant I understand that my son/daughter has been involved in the development of safety procedures, and/or has had a discussion around safe practice and risk management strategies. I understand that the school does not accept responsibility for loss or damage to personal property and that it is my responsibility to check my own insurance policy. I understand as a matter of school EOTC policy, that no alcohol or illicit drugs will be used on the EOTC event.

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/Caregiver** **or Adult participant:** | Print Name: …………………………………………….. | Signed …………………………….…… | Date: ………… |

|  |  |  |  |
| --- | --- | --- | --- |
| Volunteer Name: |  | Please return this form to school by: |  / / |
| Trip: |  | Learning Advisor: |  |
|  |
| 1. Please tick if the participant experiences any of the following: |  | 2. Is the Participant currently taking medication?  Yes ☐ No ☐ |  | 4. Is the Participant allergic to any of the following?  |
| Migraine | ☐ |  | If YES, please state: |  | Allergy ☐ | Please specify |
| Diabetes | ☐ |  | Name of medication: |  | Medication ☐ |  |
| Epilepsy | ☐ |  |  |
| Travel Sickness | ☐ |  | Dosage and time to be taken: |  | Food ☐ |  |
| Chronic nose bleeds | ☐ |  | Ailment(s) and/or Other treatment(s) |  |
| Colour blindness | ☐ |  |  | Insect bites /stings ☐ |  |
| Heart condition | ☐ |  |  |
| Sleepwalking | ☐ |  |  | Other allergies☐ |  |
| Anxiety | ☐ |  | 3. Has the Participant had any major injuries (breaks or strains) or illness (glandular fever etc) in the last six months that may limit full participation in any activities? |  |
| Bed-wetting | ☐ |  |  | What treatment is required? |
| Dizzy spells | ☐ |  |  |
| Asthma | ☐ |  | Yes ☐ No ☐ |  |
| Fits (any type) | ☐ |  | If YES, please state the injury/illness: |  | 5. Is the Participant’s tetanus injection up to date? |
| Other (please specify) |  | Yes ☐ Date: No ☐ Does not have tetanus injections. ☐ |
|  |  |  |
| 6. Outline any dietary requirements: |
| Vegetarian ☐Vegan ☐Other ☐ |
|  |
| 7. What pain/flu medication can the participant be given if necessary? Please state:  | Yes ☐ No ☐ |
| 8. To the best of your knowledge, has the participant been in contact with any contagious or infectious diseases in the last four weeks? | Yes ☐ No ☐ |
| If YES, please give brief details |
| 9. Is there any information the staff should know to ensure the physical and emotional safety of the participant? (For example cultural practices; disability; anxiety about heights/darkness/small spaces; pregnancy; behaviour or emotional problems). | Yes ☐ No ☐ |
| If YES, please state or attach the information. |
|  |  |
| Please read the following and initial if you, the Parent/Caregiver/Adult Participant, agree to these expectations | **Please Initial** |
| I also agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened and handed to the designated adult with instructions on its administration. |  |
| I will inform the school as soon as possible of any changes in the medical information or other circumstances between now and the commencement of the event. |  |
| I agree to my daughter/son myself receiving any emergency medical, dental, or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present. |  |
| Any medical costs not covered by ACC or a community service card will be paid by me. |  |
|  |
| Print name: |  | Date: |  |
| Signed: |  | Medic Alert number(if applicable) |  |

#### Health Profile: INFORMATION ON THIS FORM WILL BE AVAILABLE TO BY LEARNING ADVISORS INVOLVED IN THE TRIP. PLEASE ADD

#### PLEASE INCLUDE ANY ADDITIONAL INFORMATION IF NECESSARY AND DISCUSS ANY HEALTH OR OTHER TRIP RELATED CONCERNS THAT MAY BE RELEVENT WITH LA’s INVOLVED IN THE TRIP