



Chinchilla State High School

Learning together for a happy and productive future

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EXCURSION/ACTIVITY _____ DATE: _____

Privacy notice

The Department of Education is collecting the personal information requested in this form in order to:

- obtain lawful consent for your child to participate in the activity;
- help coordinate the activity;
- respond to any injury or medical condition that may arise during, or as a result of the activity; and
- update school records where necessary.

The information will only be accessed by authorised school staff and will be dealt with in accordance with the confidentiality requirements of, as applicable, s.426 of the Education (General Provisions) Act 2006 (Qld), the Information Privacy Act 2009 (Qld), and/or the Privacy Act 1988 (Cwlth).

The information will not be disclosed to any other person or agency unless the disclosure is authorised or required by law, or you have given the department permission for the information to be disclosed

Activity Risks & Insurance

The activity outlined above carries an inherent risk of physical injury occurring. Please note that the Department of Education, Training and Employment does not have personal accident insurance cover for students. If your child is injured as a result of an accident or incident, 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 be also be covered by your provider. Any other costs must be covered by parents/carers. It is up to all parents/carers to decide what types and what level of private insurance they wish to arrange to cover their child. Please take this into consideration in deciding whether or not to allow your child to participate in this activity.

Please complete the required information and check all appropriate boxes below to indicate your agreement/consent: The form is to be returned to (teacher's name) by (date)

Family Name: _____ Given Names _____

Date of Birth ____/____/____ Year Level _____

- ☐ I have read all of the information contained in this form in relation to the activity (including any attached material) and I am aware that the Department of Education, Training and Employment does not have personal accident insurance cover for students.
- ☐ I give consent for my child, _____ (print child's name) in class _____ (print class details), to participate in the activity detailed above.
- ☐ I have read all of the information contained in this letter in relation to the high/extreme activity activity name and consent/do not consent for my child to participate in this activity.
- ☐ I agree to pay to the school the costs detailed above for my child's participation in the activity.
- ☐ In the event of an accident or illness, I authorise school staff to obtain or administer any medical assistance or treatment my child may reasonably require, including contacting my child's doctor.
- ☐ I hereby give permission for my child to administer his / her own asthma medication.
- ☐ I am aware that in the event of severe allergic reaction (anaphylaxis) an EPIPEN may be administered by school staff.
- ☐ I agree to pay any ambulance, medical, dental and / or pharmaceutical expenses incurred on behalf of the above student which are not covered by my medical benefits fund (or travel insurance in the case of overseas travel).
- ☐ I have provided the school all relevant details relating to my child's medical or physical needs on enrolment and where relevant have updated this information.
- ☐ I accept liability for all costs incurred in obtaining such medical assistance or treatment (including any transportation costs) and undertake to reimburse the State of Queensland (via the Department of Education, Training and Employment) the full amount of any costs incurred on my child's behalf.

Parent/Carer Name _____
(Please Print)

Parent/Carer's Signature: _____ Date: ____/____/____

Additional medical information

The school collected medical information about your child at registration/enrolment. This information is stored electronically in OneSchool. Please give full details of any new or updated medical information which may affect your child's full participation in the activity described in the form. _____

You may also wish to update/provide the following optional information*:

Name of child's medical practitioner: _____ Telephone No.: _____

Medicare No.: _____

Private Health Insurance Company (if applicable): _____ Membership No.: _____

*If a registration/enrolment form for your child was completed or updated since October 2012 and these details have not changed, this information will already be recorded in OneSchool.

☐ I would like this additional information about my child's medical information to be recorded in OneSchool records.

MEDICAL CONDITIONS:

☐ My child does not have any known medical conditions.

Date of most recent tetanus injection: ____/____/____

Please indicate below any known medical conditions relevant to the above-named student.

Medical Condition	Details
<input type="checkbox"/> Heart	
<input type="checkbox"/> Respiratory e.g. asthma	
<input type="checkbox"/> Allergies e.g. food / drug / other	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Blood pressure	
<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Recent illness / Injuries/operations	
<input type="checkbox"/> Special dietary requirements	
<input type="checkbox"/> Other eg. Phobias	

5. CURRENT PRESCRIBED MEDICATION(S)

- The medication(s) listed below has / have been prescribed for my child by a registered medical practitioner and will be required to be administered while my child is involved in the excursion indicated in Section 1.
- I hereby request the teacher accompanying the excursion who has been so authorised by the Principal to administer the medication(s) in accordance with the instructions written on the medication container(s) by the pharmacist in accordance with the medical practitioner's instructions.
- I understand that all unused medication(s) will be returned to me.

Name of Medication	Dosage	Times for Administration