

FORM 2



CONSENT FORM FOR 2019 INSTRUMENTAL MUSIC CONCERT BAND WORKSHOP

(To be completed in conjunction with medical information and activity information sheets)

PLEASE USE BLOCK LETTERS WHEN FILLING OUT THIS FORM

AS A PARENT/GUARDIAN OF (CHILD'S NAME):	
I, (PARENT/GUARDIAN NAME):	
GIVE CONSENT FOR HIM/HER TO PARTICIPATE IN:	INSTRUMENTAL MUSIC CONCERT BAND WORKSHOP – 2019
DATES:	TUESDAY, NOVEMBER 5 AND WEDNESDAY, NOVEMBER 6, 2019
LOCATION:	RIDLEY CENTRE, ADELAIDE SHOWGROUND (Wayville, Adelaide)
PARENT EMAIL CONTACT:	
MOBILE PHONE NUMBER:	
INSTRUMENT:	SCHOOL:

Has a current Health care Plan been provided to Instrumental Music?

Yes ☐ No ☐

If No, please provide an updated Health Care Plan to the school/preschool on completion of this form.

Details of planned activities, transport arrangements, anticipated number of students/children and supervising teachers/instructors are provided on the information sheets distributed.

Agreement

- I agree to delegate my authority to Instrumental Music staff. Such supervisors may take whatever disciplinary action they deem necessary to ensure the safety, well-being and successful conduct of the students as a group and individually.
- In the event of an accident or illness and contact with me being impracticable or impossible, I authorise the IM teacher-in-charge to arrange whatever medical or surgical treatment a registered medical practitioner considers necessary. I will pay all medical and dental expenses incurred on behalf of my child.
- I have also attached additional or updated health care information, including details of any additional health support he/she requires to undertake the above activities safely. I also consent to my child's doctor or medical specialist being contacted in an emergency.
- The information given is accurate to the best of my knowledge.

Signed: _____

Date: / /

Emergency Contacts - Parent/Guardian

NAME			
ADDRESS			
	POSTCODE		
HOME	ALT. TELEPHONE		
Student Medic Alert Number (If applicable):			

*Any health care information provided is not intended to prevent your child participating unless specific medical advice warrants exclusion. The health care information you supply to Instrumental Music (Department for Education) will be treated confidentially. Such information is sought in order to protect and assist the student so the activity may be a safe and enjoyable experience. Please contact the IM teacher-in-charge if you wish to discuss any health care problems. The Department for Education CAMPS & EXCURSIONS GUIDELINES FOR SCHOOLS & PRESCHOOLS is available at: <https://www.sa.gov.au/topics/education-and-learning/schools/school-life/camps-and-excursions>



Consent Form – Child/Student

Permission to use image, video, voice, and/or creative work of students and children

The Department for Education develops teaching, learning and promotional materials and publishes them in print and digitally (eg on websites and social media accounts). Students also publish their own materials on websites (eg school website, department website, Scootle™, iTunes™ or other online environments).

By completing and returning this form, I grant permission for the Department for Education to create/use:

- photographs, video or audio recordings of my child
- samples of my child's work
- my child's first name and school/preschool/service name

and to distribute them in the following locations:

- printed publications (eg newsletters, year book, promotional material)
- secure intranet websites and publicly accessible websites, including social media accounts.

The permission will continue until I revoke permission in writing to the principal of the school, director of the preschool or manager of the service.

Any material placed on publically accessible websites under a CC-BY-NC licence will be available to download and use. This licence is perpetual (forever), free, worldwide, non-exclusive and allows for the replication, distribution, display, performance and remixing of copyrighted work for non-commercial purposes, provided that the author is credited.

Notes

- Items might not appear in exactly the form in which they have been submitted and not every item for which permission is granted will be used.
- Items which contain images/references to Aboriginal and Torres Strait Islander people may be accompanied by warning text to indicate that the work may include people who have passed away.
- Where permission is revoked, every effort will be made to remove relevant media from distribution, however this may not be possible or practical in some situations.

Signatures

Additional optional permissions (tick if yes)

- ☐ I also grant permission for my child to be photographed/recorded by external media organisations for publication/broadcast.

Name of child/student:	_____	
	(Full name - please print)	
Name of school/service:	_____	
Parent/guardian's signatures:	_____	_____
	(Parent/guardian to sign)	(Parent/guardian to sign)
Full name of parent(s)/guardian(s):	_____	_____
	(please print)	(please print)
Date:	_____	

Please provide signatures of both parents and/or guardians where possible.

This form must be filed in a central location at the school





Government
of South Australia

This form is developed in partnership and has co-ownership with the South Australian
Department for Education and the Department for Health and Wellbeing, Women's and Children's Health Network

Non-specific Health Care Plan

for education and care

CONFIDENTIAL

To be completed by the treating health professional and parent or legal guardian for a child or young person requiring
additional care or supervision related to their physical or mental health and wellbeing.
(Note: other proformas are available for more specific health care plans)
This information is confidential and will be available only to relevant staff and emergency medical personnel.

Name of child/young person:

DOB:

Review date:

Allergies:

Education or care service:

DESCRIPTION OF THE CONDITION

It is not necessary to provide a full medical history. Education and care staff only need to know information relevant to the child or young
person's attendance, learning and wellbeing in education and care settings.

Provide details

IMPLICATIONS FOR EDUCATION AND CARE SETTINGS

Only include information that is relevant for supervising staff to teach and care for the child or young person (for example):

- ☐ Impact on capacity to attend and participate in routine learning activities
- ☐ Limitations on physical activity
- ☐ Need for rest and/or privacy
- ☐ Need for additional emotional support
- ☐ Behaviour management plan
- ☐ Considerations for camps, excursions, social outings

Provide details

DESCRIPTION OF WARNING SIGNS, TRIGGERS, CIRCUMSTANCES AND RECOMMENDED RESPONSE

Provide details

ADDITIONAL INFORMATION

Provide details

AUTHORISATION AND AGREEMENT

(To be signed after form has been completed)

The following settings have been considered in the development of the health care
plan and is appropriate for use in the following:

- | | |
|---|---|
| <input type="checkbox"/> Children's centre, preschool or school | <input type="checkbox"/> Childcare, Out of School Hours Care |
| <input type="checkbox"/> Camps, excursions, special event, transport (incl. aquatics) | <input type="checkbox"/> Work experience or other education placement |
| <input type="checkbox"/> Respite, accommodation | <input type="checkbox"/> Work |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Other (specify) |

Treating health professional

Print name & practice/hospital or stamp

Professional role

Email or signature

Telephone

Date



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Parent or legal guardian; or adult student

- I understand and agree with the health care plan as indicated above
- I approve the release and sharing of this information to supervising staff and emergency medical staff (if required).
- I understand staff may seek additional information and/or advice regarding the medical information contained in the individual first aid plan from the Access Assistant Program (AAP) to inform duty of care.

Name

Relationship

Email or signature

Date



Individual first aid plan for education and care

CONFIDENTIAL

To be completed by the treating medical professional and parent or legal guardian for a child or young person who requires individual first aid assistance that is not the standard first aid response.

This information is confidential and will be available only to relevant staff and emergency medical personnel.

Name of child/young person:

DOB:

Review date:

Allergies:

Education or care service:

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INDIVIDUAL FIRST AID PLAN
Health Support Planning

The child or young person has a medical condition described as

The individual first aid plan is prepared in the event of

And will required the following first aid response when the follow observations are observed:

OBSERVABLE SIGN

FIRST AID RESPONSE

	⇒	⇒	
	⇒	⇒	
	⇒	⇒	
	⇒	⇒	
	⇒	⇒	
	⇒	⇒	
	⇒	⇒	
	⇒	⇒	
	⇒	⇒	
	⇒	⇒	



Individual first aid plan for education and care

CONFIDENTIAL

AUTHORISATION AND AGREEMENT (To be signed after form has been completed)		The following settings have been considered in the development of the individual first aid plan and is appropriate for use in the following:	
<input type="checkbox"/>	Children's centre, preschool or school	<input type="checkbox"/>	Childcare, Out of School Hours Care
<input type="checkbox"/>	Camps, excursions, special event, transport (incl. aquatics)	<input type="checkbox"/>	Work experience or other education placement
<input type="checkbox"/>	Respite, accommodation	<input type="checkbox"/>	Work
<input type="checkbox"/>	Transport	<input type="checkbox"/>	Other (specify)

Treating health professional		
(print name & practice/hospital or stamp)	Professional role	
	Provider number	
	Email or signature	
Telephone	Date	
Treating health professional		
(print name & practice/hospital or stamp)	Professional role	
	Provider number	
	Email or signature	
Telephone	Date	
Treating health professional		
(print name & practice/hospital or stamp)	Professional role	
	Provider number	
	Email or signature	
Telephone	Date	
Treating health professional		
(print name & practice/hospital or stamp)	Professional role	
	Provider number	
	Email or signature	
Telephone	Date	

Parent or legal guardian; or adult student	
<ul style="list-style-type: none"> I understand and agree with the individual first aid plan as indicated above I approve the release and sharing of this information to supervising staff and emergency medical staff (if required). I understand staff may seek additional information and/or advice regarding the medical information contained in the individual first aid plan from the Access Assistant Program (AAP) to inform duty of care. 	
(name)	(relationship)
(email or signature)	(date)

HSP124

INDIVIDUAL FIRST AID PLAN
Health Support Planning