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Year 5 Camp (Alexandra Park, Alexandra Headland)
Wednesday 30 October – Friday 1 November 2024

August 2024

Dear Parents and Caregivers,

Year 5 students are invited to attend camp at Alexandra Park, Alexandra Headland, to further build leadership and team skills throughout a range of different activities between Wednesday 30 October – Friday 1 November 2024. All families will receive an activity consent request and invoice via Qparents.

In addition to the activity consent form, all of the following forms must be completed and signed and returned to your child's classroom teacher by **Thursday 3 October 2024.** Any ammendments made after this date must be made directly with your child's classroom teacher.

It is vital that the forms are completed in full. Students who return incomplete and /or unsigned forms will not be able to attend the Year 5 camp.

Important information regarding administration of 'as-needed' medication while on camp:
Where medication is to be taken as needed in response to a student's symptoms (e.g. toothache, migraine), the school requires clear instructions to enable non-medically trained school staff to safely administer the medication. The school will require a completed Medication order to administer ***as-needed*** medication on camp (Appendix 2).

Yours sincerely

Will Windsor
Deputy Principal Year 5

Coorparoo State School

Year 5 Camp (Alexandra Park, Alexandra Headland)
Wednesday 30 October – Friday 1 November 2024

Student Name: _____ Student Class: _____

Parent/Carer	Name:		
	Phone number:		
	Email address:		
	Signature:		Date:
Emergency contact information for this excursion	Name:		
	Phone number/s:		

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.

Example Activity Schedule: Please note this is a draft schedule and activities may change prior to or during the camp. Please also note that all meals commencing and ending with lunch on the first and last day will be provided.

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Surf Safety Talk by Surf Life Saving Queensland or Initiative Activities						
Lunch						
Surf	Rock Climbing	Archery Game-Play	High Ropes	Beach Games	High Ropes	Canoeing
Afternoon Tea						
Canoeing	Surf	Rock Climbing	Archery Game-Play	High Ropes	Beach Games	High Ropes
Move into cabins, Free Time, Showers etc						
Dinner						
Breakfast						
High Ropes	Canoeing	Surf	Rock Climbing	Archery Game-Play	High Ropes	Beach Games
Morning Tea						
Beach Games	High Ropes	Canoeing	Surf	Rock Climbing	Archery Game-Play	High Ropes
Lunch						
High Ropes	Beach Games	High Ropes	Canoeing	Surf	Rock Climbing	Archery Game-Play
Afternoon Tea						
Archery Game-Play	High Ropes	Beach Games	High Ropes	Canoeing	Surf	Rock Climbing
Free Time, Showers etc						
Dinner						
Breakfast						
Pack Up/Clean Up						
Rock Climbing	Archery Game-Play	High Ropes	Beach Games	High Ropes	Canoeing	Surf
Morning Tea						
Team Building Initiatives						
Lunch						
Depart Campsite						

Coorparoo State School

Year 5 Camp (Alexandra Park, Alexandra Headland)
Wednesday 30 October – Friday 1 November 2024

Student health information

This form is to provide school staff organising excursions, camps or other off-site school activities with confidential health information about a student which may affect their full participation in the activity.

Privacy Statement

The Department of Education is collecting this personal information in order to support the health needs of the named student during the excursion identified below. The information will only be used by authorised employees of the department. The information will not be given to any other person or agency unless we have your consent, or we are required by law to do so.

Name of excursion	**Year 5 Camp**
Date/s of excursion	**Wednesday 30 October – Friday 1 November 2024**

1: Student & parent/carer details			
Student name			
Date of birth		**Year level / Class**	
Parent/carer name			
Medicare number			
Private Health Insurance Fund name		**Membership number**	
Medical practitioner name		**Contact phone number**	

2: Health conditions		
2.1. Does the student have any health conditions that the school has not been previously advised of?	☐ Yes *(go to 2.2)*	☐ No *(go to 2.3)*
2.2. Indicate the student's health condition/s: ☐ Asthma ☐ Anaphylaxis ☐ Diabetes ☐ Epilepsy ☐ Other: _____ Contact the student's teacher/activity coordinator as soon as possible to plan for any support or reasonable adjustments required to manage the student's health condition. For example, if the student requires medication or if they require additional overnight support e.g. catheterisation, gastrostomy, blood glucose testing.		
2.3. Does the student have any current or previous injuries that may affect their participation that the school has not been previously advised of?	☐ Yes *(go to 2.4)*	☐ No *(go to 3)*
2.4. Describe the injury:		

Coorparoo State School

Year 5 Camp (Alexandra Park, Alexandra Headland)
Wednesday 30 October – Friday 1 November 2024

3: Medication requirements		
3.1 Will the student require medication during this excursion?	☐ Yes *(go to 3.2)*	☐ No *(go to 4)*
3.2 Does the student require staff to administer their medication?	☐ Yes *(go to 3.4)*	☐ No *(go to 3.3)*
3.3 Does the student have approval to self-administer their medication at school?	☐ Yes	☐ No
3.4 Does the medication require special storage?	☐ Yes	☐ No

If the answer was **YES** to any of the questions above:

- complete and attach a *Consent to administer medication* form (page 6) and any relevant advice from the health practitioner e.g. action plan, letter, medication order
- contact the student's teacher as soon as possible to ensure that the student's medication needs can be supported.

4: Dietary requirements		
4.1 Does the student have specific dietary requirements?	☐ Yes	☐ No
REGARDLESS OF RESPONSE ABOVE (4.1), PLEASE ALSO COMPLETE AND RETURN APPENDIX 1: DIETARY INFORMATION FORM		

5: Travel and away-from-home issues		
5.1. Does the student experience travel/motion sickness? If **YES** and the student requires medication for travel/motion sickness, complete the *Consent to administer medication form* (page 6) and provide the school with the medication.	☐ Yes	☐ No
5.2 Does the student require night bedwetting management or require an appliance / device at night to support a health condition? If **YES**, describe what aid / appliance / support is required:	☐ Yes	☐ No
5.3 Does the student sleep walk, have night terrors, have fears/phobias, experience anxiety, or have any other issue/s that may impact on their participation in this excursion? If **YES**, describe the actions required to manage these:	☐ Yes	☐ No

6: Declaration			
I have reviewed the information provided in this form and confirm that this information is accurate.			
Name of parent/carer			
Signature		**Date:**	

Coorparoo State School

Year 5 Camp (Alexandra Park, Alexandra Headland)
Wednesday 30 October – Friday 1 November 2024

Consent to administer medication

PLEASE NOTE:

For medication to be administered at school or during school-related activities, there must be medical authorisation for the student to have that medication, and the medication must be in its original container with intact packaging.

Examples of medical authorisation include:

- a pharmacy label with both the student's and doctor's name on it;
- a signed letter from a doctor;
- a medication order from a dentist;
- an Action Plan signed by a doctor or nurse practitioner.

See below for examples of health conditions, medications and associated documentation:

Health condition/ reason for medication	**Example of medication**	**Documentation completed by doctor or other prescribing health practitioner**
Asthma	Asthma puffer	*Asthma action plan*
Anaphylaxis	EpiPen	ASCIA *Anaphylaxis Action Plan*
Diabetes	Insulin injection, insulin pump	Department of Education *Medication order to administer 'as-needed' medication at school* or medication order or *diabetes management plan* or other written instructions from prescribing health practitioner
Other types of emergency medication e.g. for seizures	Midazolam	Department of Education *Medication order to administer 'as-needed' medication at school*
Medication required 'as needed' for minor or non-emergency symptoms	Ointment for skin allergies, paracetamol, antihistamines	**APPENDIX 2: Department of Education *Medication order to administer 'as-needed' medication at school***
Changes to dosage (e.g. from ½ to 1 tablet)	Ritalin	Written instructions from prescribing health practitioner (e.g. doctor)

To request that the school administer medication to a student

1) Complete Section **A**.
2) Provide the school with the medication in the original container with intact packaging.
3) Provide the written medical authorisation (e.g. completed pharmacy label, medication order, action plan) completed and signed by the prescribing health practitioner.
4) Make an appointment with the principal/delegate if:
   - the student requires medication as an emergency response;
   - you would like the student to self-administer their medication;
   - the student has complex health support needs or requires other support strategies; or
   - you have any concerns about the student's health which may affect their schooling.

To request a student self-administer their medication

1) Complete Section **A** and Section **B**.

Coorparoo State School

Year 5 Camp (Alexandra Park, Alexandra Headland)
Wednesday 30 October – Friday 1 November 2024

Consent to administer medication

Privacy Statement

The Department of Education (DoE) is collecting this personal information for the purpose of enabling school staff to administer medication to the nominated student, or to support a student to self-administer their medication while at school or during school-related activities. This information will only be accessed by authorised departmental employees. In accordance with section 426 of the *Education (General Provisions) Act 2006* (regarding student's personal information) and the *Information Privacy Act 2009* (parent/carer's personal information) this information will not be disclosed to any other person or body unless DoE has been given permission or is required or authorised by law to disclose the information.

Section A: *Complete the details below:*

NOTE: This form only collects information for one (1) medication. If more than one medication is required, please complete a separate form for each medication.

Student name		**Date of birth**	
Parent/carer name		**Phone number**	

- I consent to the following medication being administered (as per the instructions on the pharmacy label and/or any additional written instructions) to the student named above during school or school-related activities.
- I authorise school staff to contact the prescribing health practitioner or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication to this student.

Name of medication	

I confirm that the medication provided to the school (as listed above):

☐ is medically authorised *(e.g. has been prescribed by a doctor, dentist, optometrist or nurse practitioner)*

☐ is in the original dispensed container with intact packaging

☐ has the student's and doctor's names on the pharmacy label *(if there is no other written evidence of medical authorisation)*

☐ is current/in-date *(*The expiry date of the medication is _ _ /_ _ /_ _ _ _*).*

The medication is required:		If **Yes** to any questions, complete the following:
(a) routinely (e.g. 11am every day)	☐ **No** ☐ **Yes⇨**	Administer at _ _: _ _ am/pm on the following days: *(circle the day/s required)* Monday Tuesday Wednesday Thursday Friday
(b) for a short time only (e.g. only for 2 weeks)	☐ **No** ☐ **Yes⇨**	Start date: _ _ /_ _ / _ _ _ _ End date: _ _ /_ _ / _ _ _ _
(c) to manage a health condition by following a current action plan or health plan	☐ **No** ☐ **Yes⇨**	Is the medication for: ☐ asthma ☐ anaphylaxis ☐ diabetes ☐ epilepsy ☐ cystic fibrosis ☐ other *(describe)*
(d) 'as needed' to treat minor or non-emergency symptoms	☐ **No** ☐ **Yes⇨**	☐ I understand that before the school administers this medication, if they are not aware of when this medication was most recently given to this student, I will be contacted to provide this information.

Has this student previously shown any side effects after taking this medication?	**Yes** ☐ **No** ☐
If **Yes**, describe:	

Parent/carer/signature		**Date**	

Coorparoo State School

Year 5 Camp (Alexandra Park, Alexandra Headland)

Wednesday 30 October – Friday 1 November 2024

If the student is to self-administer this medication, also complete **Section B NOTE: Controlled drugs cannot be self-administered.**

Section B*: Details for student self-administration of medication:*

In all cases and at any time, the principal/delegate may disallow student self-administration for health and/or safety reasons.

Student name		**Date of birth**	

- I confirm that the student is confident, competent and can safely administer the right dose of their own medication at the right times.
- I confirm that the student can store their medication securely.
- I authorise school staff to contact the prescribing health practitioner, health team or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication by this student.

Health condition	I seek approval from the principal/delegate for the student to self-administer:
☐ Asthma	☐ their asthma medication *(following a current action plan/health plan)*
☐ Anaphylaxis	☐ their adrenaline auto-injector *(following a current action plan/health plan)*
☐ Diabetes	☐ their medication *(following a current health plan)*
☐ Cystic fibrosis	☐ their medication *(following a current health plan)*
☐ Other _____	☐ their medication *(following a current health plan)*

Parent/carer/student signature		**Date**	

Coorparoo State School

Year 5 Camp (Alexandra Park, Alexandra Headland)
Wednesday 30 October – Friday 1 November 2024

APPENDIX 1

DIETARY REQUIREMENTS INFORMATION

CAMP CAN CATER FOR: Dairy/Lactose Free, Gluten Free, Seafood Free, Vegetarian, Egg Free (whole egg only), Nut Free, Halal (No Pork & No Beef).

CAMP CAN NOT CATER FOR: Soy, sesame, preservatives, flavours and colour free diets and/or allergies. In the event a diet/allergy falls outside of our catered-for list or if they exceed more than two of the listed diets we will not be able to cater for these either.

My child _____

☐ **does not have any dietary requirements for the 2024 Year 5 Camp.**

☐ **does have dietary requirements for the 2024 Year 5 Camp as indicated below:**

LACTOSE/DAIRY FREE (LF/DF)	
GLUTEN FREE (GF)	
SEAFOOD FREE (SF)	
VEGETARIAN (V)	
EGG FREE (WHOLE EGG ONLY) (EF)	
HALAL, NO PORK AND NO BEEF	
NUT FREE** (NF)	

PLEASE NOTE: **NUT FREE - For Nut Allergies we must emphasise that while we are able to take every reasonable effort to avoid the use of nuts or peanut derivatives in prepared food, it is impossible for us to guarantee that an attendee will not come in contact with nuts, nut derivatives or nut residue during their stay. Camp sites have a 'NUT FREE' policy, please do not bring any type of nuts onto the premises.

Please advise below if you require the school to contact you directly in regards to any of these allergies:

Please contact me on (Phone number) _____ to discuss the above allergies.

Parent/carer name: _____

Signature: _____

Date: _____

Coorparoo State School

Year 5 Camp (Alexandra Park, Alexandra Headland)
Wednesday 30 October – Friday 1 November 2024

APPENDIX 2

Medication order to administer 'as-needed' medication at school

Where medication is to be taken as needed in response to a student's symptoms (e.g. toothache, migraine), the school requires clear instructions to enable non-medically trained school staff to safely administer the medication. The school will require:

- specific written instructions e.g. where school staff are required to administer medication as part of a health procedure (e.g. administration of medication through a gastrostomy tube) or
- a completed Medication order to administer as-needed medication at school

The following information will be used by Queensland state school staff to support the administration of 'as-needed' medication to the student named below at school or during school-related activities (e.g. camps, excursions).

Prescribing health practitioner to complete all sections below:			
Student name		**Date of birth**	
Medication		**Dosage and route**	
This medication is to be administered as: *(please select one or both)* ☐ an emergency response ☐ a non-emergency response			
Administer the medication when these signs and symptoms occur:			
The maximum number of dosages allowed over a 24-hour period are:			
The minimum length of time allowed between dosages is:			
The expected response the student would have after having this medication administered is: If there is no response in approximately ____ minutes, take the following action [e.g. call ambulance]: ***Please note:*** *The school will notify the parent/carer if the student displays any suspected side effects following administration.*			
Please indicate if additional information is attached (if required): YES ☐ NO ☐			

Name of prescribing health practitioner:	Medical practice stamp/sticker:
Signature of prescribing health practitioner:	
Date:	
Review date of this medication order:	