



## Rockhampton & District Trials 2022

### VOLLEYBALL

<b>Age/s:</b>	12-15 Years & 16-19 Years
<b>Venue:</b>	Rockhampton SHS
<b>Transport:</b>	Please notify Sports Department if transport is needed and arrangements will be made.
<b>Date:</b>	Friday 25th February 2022
<b>Cost:</b>	\$10 (this will be added to the student's school levy)
<b>Time:</b>	11am – 12:30pm
<b>What to bring:</b>	Hat, sunscreen, water bottle and appropriate equipment.

**No student will be allowed to participate without the following consent slip being fully completed, including signature and returned to the college and the relevant fee paid online or in person.**

Dallas Williams

*Director of Sport*

✂.....✂.....✂.....✂.....✂.....✂.....✂

I \_\_\_\_\_ agree that my son \_\_\_\_\_ can

(Parent/Guardian) Please print

participate in the R&D VOLLEYBALL Trials.

Signed \_\_\_\_\_

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

(Parent/Guardian)



### Parental Permission/Student Medical Information

Students Name: \_\_\_\_\_ School: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male / Female

Sport Trial Attending: \_\_\_\_\_ Date of Trial: \_\_\_\_\_

Preferred Playing Positions (Please list 2 if possible): \_\_\_\_\_

Emergency Contact Name and Phone Number: \_\_\_\_\_

**Student Medical Information** I submit the following medical information about the above student and include details of limitations which she/he has for the activity concerned.

Does/has the student suffered from -		(detail current medication/management)
a.	Allergies	Yes / No _____
b.	Asthma	Yes / No _____
c.	Blood pressure	Yes / No _____
d.	Drug reaction	Yes / No _____
e.	Epilepsy	Yes / No _____
f.	Heart problems	Yes / No _____
g.	Operations	Yes / No _____
h.	Phobias	Yes / No _____
i.	Recent illness	Yes / No _____
j.	Respiratory problems	Yes / No _____
k.	Travel sickness	Yes / No _____

Detail any other medical /injuries / problems which may limit participation in the activity

Immunization Record - Hepatitis B Yes / No Year \_\_\_\_\_ Tetanus Yes / No Year \_\_\_\_\_  
Other \_\_\_\_\_

Detail any medication(s) your daughter/son/ward is currently using \_\_\_\_\_

Does your daughter/son/ward have -  
Medicare Card Yes / No Card No. \_\_\_\_\_ Expiry date \_\_\_\_/\_\_\_\_/\_\_\_\_ cardholder name \_\_\_\_\_  
Private Health Ins Yes / No With \_\_\_\_\_ Expiry date \_\_\_\_/\_\_\_\_/\_\_\_\_ cardholder name \_\_\_\_\_  
Card No. \_\_\_\_\_ Category \_\_\_\_\_

Have you been diagnosed as having Covid 19? Yes / No  
Have you had contact with a known Covid 19 case in the last 14 days? Yes / No  
Have you returned from overseas travel in the past 14 days? Yes / No

Playing history:

#### **Principal's Declaration**

- I certify that the student whose details appear on this form is enrolled at this school.
- I have verified that the date of birth as stated on this form is correct.
- He/she has the school authority to represent on this occasion.
- A copy of this consent form will be retained by my school.

SIGNED: \_\_\_\_\_ (Principal or Sports Coordinator) \_\_\_\_\_ (Date)

#### **Parental/Caregiver Consent**

- I have read the information issued and I hereby consent to my child participating in this event.
- I understand that teachers will provide supervision at the event.
- I understand that transport to and from the event is my responsibility and that the arrival and departure arrangements are also responsibility of the parent/caregivers unless otherwise specified.
- In the event of any accident or illness, I authorise the obtaining, on my behalf, an ambulance and any such medical assistance that my child may require. I accept full responsibility for all expenses incurred.
- I understand that mouth protection is mandatory in this sport (AFL, RU, RL, Water Polo, Hockey). I have read the information provided to me about mouth protection and accept responsibility for the type of mouth protection I/my child will wear whilst playing this sport.

SIGNED: \_\_\_\_\_