TOWNSVILLE GRAMMAR SCHOOL

sony FOUNDATION

IMPORTANT
Please attach child's photo here.

Thank you

The Sony Foundation Children's Holiday Camp at Townsville Grammar School
18 – 20 September, 2021.

THIS BOOKLET NEEDS TO BE COMPLETED AND RETURNED BY Friday, 6 August 2021 TO:
Townsville Grammar School
45 Paxton Street
North Ward Qld 4810

APPLICATION/INFORMATION BOOKLET

Child's Surname: _____ **First Name:** _____

Date of birth: _____/ _____/ _____ Age: _____ Weight: _____

Please Circle: Female / Male Shirt size: Child - 6 / 8 / 10 / 12 / 14 OR Adult - S / M / L / XL

Child's Disability - Please provide a description of your child's diagnosis (if known): _____

_____

_____

Child's School: _____ School phone number: _____

Medicare No: _____ **Position on card:** _____ **Expiry:** _____

Health Care Card No: _____ **Expiry:** _____

Private Health Insurance: ☐ **Yes** ☐ **No** **If YES name of Health Fund & Membership No.**

_____

Which hospital does your child usually attend? _____

Doctor who prescribes your child's medication: _____

Phone: _____ Fax: _____ Email Address: _____

Doctor's Address: _____

_____

_____

Date of last tetanus injection: _____

CHILD'S NAME: **DOB:**

Child lives with - Name:

Address:

Phone - Home: Mobile: Business:

Email Address:

If details below are the same as previous question, 'Child lives with', please write 'As above'.

Mother's Name:

Address:

Phone - Home: Mobile: Business:

Father's Name:

Address:

Phone - Home: Mobile: Business:

EMERGENCY CONTACT
(other than 'Child lives with Name' e.g. Grandparent, Aunt, Friend)

Name:

Phone: Relationship to child:

RESPITE

Please circle the regular respite or support assistance you receive:

DAILY **WEEKLY** **MONTHLY** **FAMILY** **OTHER**

Discuss the type of respite you receive:

Reasons for recommendation: Give any reason (e.g. home circumstances, suitability of this particular holiday for the child).

Name of person recommending child:

Relationship to child: Phone:

CHILD'S NAME: **DOB:**

ALLERGIES – Please complete all questions or mark 'NIL'

FOOD: _____ DRUG: _____

OTHER ALLERGIES i.e. balloons (latex): _____

REACTION: _____

PLEASE CIRCLE YES OR NO - If YES please complete the additional **allergy form on Page 9**.

ASTHMA Has your child ever been treated for asthma: **YES / NO**
If YES please complete the additional **asthma form on Page 10**.

DIABETES Has your child ever been treated for diabetes? **YES / NO**
If YES please complete the additional **diabetes form on Page 11**.

EPILEPSY Has your child ever been treated for fits? **YES** / **NO**
If YES please complete the additional **epilepsy form on Page 12**.

ROUTINE MEDICATIONS State **medication / dose / times given / any special directions for giving medication i.e. crushed / in honey etc OR mark 'NIL'.**

1. _____

2. _____

3. _____

4. _____

Other **MEDICAL PROBLEMS, SPECIAL** or **CURRENT TREATMENTS** we should be aware of?

_____

If your child takes medication for any reason, including asthma and allergies, you will be sent a medication information pack that you will need to take to the doctor who prescribes your child's medication. Please follow the instructions carefully.

CAREPLAN INFORMATION

(Please give detailed information)

Is your child naturally quiet and reserved or is he/she more lively and outgoing?

Please circle: **Quiet** **Active** **Very active**

What are your son's/daughter's favourite hobbies? _____

_____

Places your child likes to visit: _____

Does he/she have any favourite toys? _____

Does your son/daughter have any brothers or sisters? _____

People whose company your child enjoys: _____

What are your child's favourite topics of conversation? _____

Do you have any pets? _____

Does your child support any teams or sporting individuals e.g. football, cricket, tennis, etc.?

_____

Does your child have any fears or phobias? _____

CHILD'S NAME: **DOB:**

COMMUNICATION

Please indicate your child's level of communication on the scale

1 _____2 _____3 _____4 _____5

(**very difficult to understand)** **(very clear and easy to understand)**

Please discuss methods of communication e.g. signs etc. _____

_____

How much of what is being said does your child understand? _____

_____

Does your child communicate their needs? _____

MOBILITY

Does your child require assistance or aids to walk? **YES / NO** If YES please explain: _____

_____

Does your child need a wheelchair? **YES / NO** If YES please state when and if the chair is motorised or manual: _____

Does your child need assistance in transferring? **YES / NO** If YES please explain: _____

_____

_____

Preferred way of lifting your child:

☐ Hoist ☐ one-person lift ☐ 2-person lift ☐ other _____

Favourite positions:

Day time: _____

Night time: _____

Positions to avoid: _____

_____

_____

Positions to encourage: _____

_____

_____

CHILD'S NAME: **DOB:**

HEARING AND VISION:

(Please ✓) ☐ N/A

Hearing loss: ☐ Mild ☐ Moderate ☐ Severe

Wears Heading Aids: ☐ Yes ☐ No ☐ 1 aid ☐ 2 aids

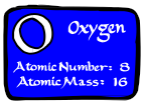
Grommets: ☐ Yes ☐ No

If grommets, does your child wear ear plugs during swimming: ☐ Yes ☐ No

Vision Impairment: ☐ Mild ☐ Moderate ☐ Severe

Wears Glasses: ☐ Yes ☐ No

OXYGEN & SUCTIONING ☐ N/A



Does your child have oxygen at home? ☐ No ☐ Yes – If YES, what is the frequency: _____

What is the rate?: _____

How is it delivered (prongs/mask, etc.): _____

Does your child require suctioning?: ☐ No ☐ Yes ☐ Oral ☐ Nasal

If YES, please provide details (frequency): _____

PERSONAL CARE

If your child is on a toileting routine, please provide details: _____

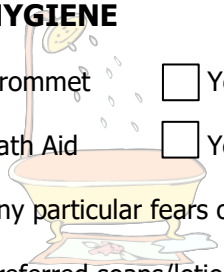
Is assistance required with toileting? If YES, please explain: _____

On average, how many pull-ups does your child require per day? If YES, please explain size / type / frequency of change: _____

Does your child require aids e.g. chair etc.? _____

If your child does require aids, will you provide them? _____

HYGIENE



Grommet ☐ Yes ☐ No Is a shower chair needed? ☐ Yes ☐ No

Bath Aid ☐ Yes ☐ No If YES, please specify: _____

Any particular fears of bathing: _____

Preferred soaps/lotions (if so, please provide & clearly mark name) _____

CHILD'S NAME: **DOB:**

DIET

Does your child have any **FOOD ALLERGIES?** ☐ Yes ☐ No If YES, please specify:

_____

_____

Does your child have a gastrostomy? ☐ Yes ☐ No If YES complete QUESTIONS 1-7.

1. Are they **Nil By Mouth**? _____
2. Do they eat food? _____
3. Do they drink fluids? _____
4. Please state feeding times: _____
5. What and how is the formula made? _____
6. How is the formula given, how long does it take to complete the feed? _____
7. State the equipment cleaning routine? _____

PLEASE CIRCLE how meals should be presented: **pureed/cut/normal/special diet/other**_____

If special diet please explain: _____

_____

Is there a problem with aspirating during feeds? If so how do you prevent this? _____

_____

How do you manage aspiration when it occurs? _____

Is mealtime assistance required? ☐ Yes ☐ No

If YES please comment on method of assistance, positioning, special utensils needed etc.: _____

_____

Breakfast:	☐ small	☐ medium	☐ large
Lunch:	☐ small	☐ medium	☐ large
Dinner:	☐ small	☐ medium	☐ large

Do you wish to provide any additional information regarding feeding or nutrition not covered above?

_____

_____

_____

CHILD'S NAME: **DOB:**

Give a list of foods your child **likes** to eat**:**

Give list of foods your child **is not able to eat (allergy).** Please only include foods your child cannot eat rather than does not like:

CHILD'S NAME: **DOB:**

SLEEPING 

Bed Time: _____ Waking Time: _____

Day Time Rest: ☐ No ☐ Yes – what times: _____ am _____ pm

Night Time sleeping pattern and desired response from carer: (Does your child wake during the night?)

_____

_____

_____

Night settling tips: _____

Sleeping Aid / Comforter: _____

Preferred sleeping position: _____

Child sleeps in a:

☐ bed with rails ☐ bed without rails

Child sleeps with lights: ☐ On ☐ Off Child sleeps with door: ☐ Open ☐ Closed

Child sleeps with nappy: ☐ Child sleeps with protective sheet: ☐

SAFETY AND BEHAVIOUR:

Does your child have any behaviour which carers need to be aware of: ☐ Yes ☐ No

At home: _____

At school: _____

On outings: _____

If YES, how do you manage this behaviour (at home/at school/on outings): _____

_____

_____

WOUND MANAGEMENT

Does your child have any wounds/sores which require dressing whilst at camp? ☐ Yes ☐ No

If YES please explain location and management _____

_____

_____

_____

_____

ALLERGIC REACTION MANAGEMENT PLAN

Name of participant: _____ Date of birth: _____

Allergy: _____

Signs and symptoms of reaction: _____

What medication does the child take (if any) for prevention of allergic reaction? _____

_____

What treatment is followed for the child if an allergic reaction occurs? _____

_____

Has the child at any time in the past suffered from (please tick):

☐ A localized reaction (any rash/itching/swelling **at** the site)

☐ A systemic reaction (any rash/itching/swelling **away** from site)

☐ An Anaphylactic reaction (severe breathing problems, swelling of body, emergency situation)

1.	Does the child suffer a systemic/anaphylactic reaction to allergy?	☐ Yes	☐ No
2.	Is there a family history of anaphylaxis?	☐ Yes	☐ No
3.	Has the child been admitted to hospital for an allergic reaction?	☐ Yes	☐ No
4.	Does the child take adrenaline (epi-pen) when suffering from an allergic reaction?	☐ Yes	☐ No

If YES was the answer to any of Questions 1 – 4, the child's medical practitioner must be consulted and documentation from the Medical Practitioner on the child's allergy management and emergency routine provided.

Other information: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CHILD'S NAME: **DOB:**

ASTHMA MANAGEMENT PLAN

Name of participant: _____ Date of birth: _____

Regular medication: _____

Quantities and daily dosages: _____

Additional medications in case of an attack: _____

The child is required to bring the above medications to camp.
Medications are self-administered under supervision of a teacher/registered nurse.

List of known trigger factors: _____

Peak Flow Readings: Expected best: _____

Requiring extra medication: _____

Requiring medical assistance: _____

Other information: _____

CHILD'S NAME: **DOB:**

DIABETES MANAGEMENT PLAN

***A letter must be supplied by your doctor stating;**
- what medications are required
- contact numbers for doctor / diabetes educator
- when to give medications.

What blood sugar level constitutes a hypo for your child: _____

What blood sugar level constitutes a hyper for your child: _____

Other information: _____

CHILD'S NAME: **DOB:**

EPILEPSY MANAGEMENT PLAN

SECTION 1: DETAILS OF CONDITION

Type of Epilepsy: _____

Please describe type of seizures experienced: _____

_____

_____

_____

Are seizures likely to occur at camp? ☐ Yes ☐ No If YES, how frequently? _____

Are there any factors or situations which may 'trigger' seizures? ☐ Yes ☐ No

If YES, please give details (including additional supervision required and any limitations in participation of any camp activities):

_____

_____

_____

SECTION 2: DETAILS OF MANAGING THE CONDITION

If your child has a seizure at camp – what should camp staff do?

Please describe procedures in detail:

_____

_____

_____

_____

_____

Under what circumstances should the Doctor be called? Please state clearly:

_____

_____

Is your child taking any medication for Epilepsy? ☐ Yes ☐ No

If YES, please complete the following:

Name of medication: _____ Strength: _____

Dosage: _____ Time to be taken: _____

CHILD'S NAME: **DOB:**

Any further comments/information: _____

_____

_____

_____

_____

_____

_____

THIS SECTION IS TO BE COMPLETED ON ARRIVAL TO SONY CAMP:

Asthma ☐

Diabetes ☐

Allergies ☐

Epilepsy ☐

SECTION 3: THE ABOVE INFORMATION HAS BEEN DISCUSSED BY:

Parent/Guardian's name: _____ Signature: _____

Date: ___/___/___

Child signature (if applicable): Signature: _____

Date: ___/___/___

Staff name: _____ Signature: _____

Date: ___/___/___

MEDICAL PROCEDURES AND CONSENT FORMS

MEDICATIONS

- It is imperative that Nursing Staff be aware of all medications taken by your child.
- Medication can only be administered if the container states, name, dose, and is labelled in the original container.
- All medications administered by the staff will be recorded.
- Medication charts must be completed for children on regular medication by the child's local doctor prior to the commencement of Camp.

IN THE EVENT OF ACCIDENT OR ILLNESS

Minor injuries, ailments

- The Registered Nurse on duty will assess, treat or refer the child to other health professionals or parent.

Serious ailments/injuries requiring doctor or hospital admission

- Parent/Guardian will be contacted if at all possible according to information on medical history form.
- First Aid will be administered by nurse, or other staff members immediately present.
- The nurse will decide if the child should be taken to hospital immediately or a doctor called.
- In an emergency or on the advice of attending doctor, a child will be transferred by ambulance to hospital. A camp representative will stay with the patient until the child's relatives attend the hospital.

MEDICAL CONSENT

As a parent / guardian of

_____

(Child's full name)

- I agree to notify the Camp staff if my child has been in contact with or has any contagious illness.
- I agree to notify the Camp staff if there is any change to my child's medical condition (from the previous information sent on the application form).
- I authorise staff to assist in the administration of medications specified on the medication chart.
- I give my consent to the treatment considered necessary or desirable by the staff.
- In the case of emergency or accident, I consent to my child being transferred to the nearest hospital.

Signed: _____ Date: _____

Please print name: _____

CHILD'S NAME: **DOB:**

CONSENT FOR ACTIVITIES

I further give my consent for (child's name)_____

- To participate in all the activities and excursions **as listed on the attached timetable** for the camp.
- I agree to delegate my authority to the staff and assistants involved. The staff at the Camp may take whatever disciplinary action they deem necessary to ensure the safety, well-being and successful conduct of the Camp and in the conduct of activities and excursions.

Signed: _____ Date: _____
(Parent/Guardian)

Print name in full: _____

CONSENT FOR SWIMMING

I give consent for (child's name)_____
to participate in swimming activities on the Camp.

Please circle which applies to your child:

- Very competent swimmer in deep water
- Swims unaided
- Requires flotation device
- Requires more than one assistant for support in the water
- Does not like swimming
- Will need ear plugs

Does your child require pull-ups for water activities? ☐ Yes ☐ No

If yes, please provide sufficient pull-ups for two sessions in the pool.

Signed: _____ Date: _____

Print name in full: _____

CONSENT FOR PHOTOGRAPHY/TV/VIDEO

Throughout the Camp photographs and videos will be taken. These photographs and videos may be shown or displayed in order to advertise or promote future Camps.

- I give permission for any such photographs and/or videos to be shown or displayed in order to advertise or promote the camp.
- I give permission for these photographs and/or videos to be used as aids to instruct carers and future staff how to conduct certain activities relevant to future camps.

Signed: _____ Date: _____

Print name in full: _____

Through special request we will be able to supply you with copies of some of the photographs taken.

CHILD'S NAME: **DOB:**

CONSENT TO ACCESS SCHOOL PROFILE FOR ADDITIONAL INFORMATION

I give consent for the school records of (child's name) _____

Name of School: _____

Address: _____

_____ Ph: _____

to be accessed to ascertain additional information which may assist in the quality of care provided at the upcoming Camp.

I hereby authorise the obtaining on my behalf of such medical assistance as my child may require in the event of accident or illness and guarantee any costs incurred.

I authorise the administering of anaesthetic if this is deemed necessary by the medical officer attending.

I acknowledge it is my responsibility to immediately inform the School if there are any changes to any of the information contained in this form. I further acknowledge that the School will rely on the information contained in this form and is entitled to assume that the information is current, unless I have informed the School to the contrary.

Signed: _____ Date: _____

(Parent/Guardian)

MEDICAL CONTINUATION SHEET