Teacher Consent Form

Camp Agreement:

I agree to my attendance at the below mentioned program.

Program Name:

Program Dates:

As a teacher I understand that Barrington Outdoor Adventure Centre and its instructors will take reasonable care for the welfare and safety of those attending the camp but are not responsible for any accident or sickness otherwise occurring. I acknowledge that going on camp may involve my participation in activities of a hazardous nature, though Barrington Outdoor Adventure Centre and its instructors will take reasonable care to minimise risk to participants.
I have detailed herein and on any attached pages any disabilities or susceptibilities affecting myself that may place me at greater than normal risk. I authorise Barrington Outdoor Adventure Centre and its instructors to obtain medical assistance and ambulance transportation in the event of illness or injury as they think necessary and authorise qualified medical practitioners to administer anaesthetic, blood transfusions or any other procedures deemed necessary. I also agree to pay all the cost of any expenses incurred as a result of such medical assistance and ambulance transportation. I acknowledge that I am able to obtain private insurance cover for myself in respect of any accidents or sickness at the camp. Should I need to go home for any reason I will cover any associated costs.

I acknowledge that during camp I may be go swimming and I give my permission to do so.

I consent to attending camp on this understanding.

Privacy Statement:

Barrington Outdoor Adventure Centre will collect and store the information you voluntarily provide to enable processing of enrolment for programs/camps. The information will be provided to instructors/guides of the program and their supervisors, where necessary and you consent to this disclosure. Any information provided by you will be stored in a database that will only be accessed by authorised personnel and is subject to privacy restriction. The information will only be used for the purpose for which it was collected. Any information provided by you to Barrington Outdoor Adventure Centre can be accessed by you during standard office hours and updated in writing or by contacting us on (02) 6558 2093.
I also declare that I have read and understand the information within the Teacher Information Pack/Guidelines and will read the gear checklist for my safe participation and will ensure I bring all items listed. I also understand that it is a condition of participation to accurately complete the following medical forms.

Media Consent:

I agree to allow Barrington Outdoor Adventure Centre to use any photographs or video taken of me at this program for the promotion of its services through promotional DVD or on BOAC websites.

Teachers Name	Teachers Signature	Date

Teacher Medical Form pg.1

Personal Details

First Name _____ **Middle Name** _____ **Last Name** _____

Date of Birth / / **Age** **Gender** MALE/FEMALE

Height _____ m **Weight** _____ kg

Residential Address _____ **Post Code** _____

Emergency Contact #1

First Name _____ **Last Name** _____ **Relationship** _____

Home Phone _____ **Work Phone** _____ **Mobile Phone** _____

Residential Address _____ **Post Code** _____

Email Address _____

Emergency Contact #2

First Name _____ **Last Name** _____ **Relationship** _____

Home Phone **Work Phone** **Mobile Phone**

Residential Address _____ **Post Code** _____

Email Address _____

Medical Information

Medicare Number _____ **Doctors Name** _____ **Doctors Phone #** _____

Medical Fund Name _____ **Membership Number** _____

Medical Cover Provider _____ **Membership Number** _____

Ambulance Cover Provider _____ **Membership Number** _____

Date of last tetanus injection / / (If not current, see doctor)

Do you currently require medication? Yes – complete medication form / No

Do you suffer from asthma? Yes – complete asthma management form / No

Do you suffer from allergies? Yes – complete allergy management form / No

Do you suffer from any of the following? (circle and complete details is applicable)

Chronic injury	No	Yes	Details: _____
Chronic illness	No	Yes	Details: _____
Emotional Disorder	No	Yes	Details: _____
Behavioural Disorder	No	Yes	Details: _____
Low/High Blood Pressure	No	Yes	Details: _____
Heart Complications	No	Yes	Details: _____
Phobias	No	Yes	Details:

Teacher Medical Form pg. 2

Sleepwalking	No	Yes	Details:	
Travel Sickness	No	Yes	Details:	
Dietary Requirements	No	Yes	Details	

If you are ill or require medical attention in the 4 weeks prior to program you must provide a medical certificate deeming yourself fit for program.

Swimming Skills

Please indicate your Childs swimming skills below:

Swimming Skill	✓
Non-swimmer – Has not yet learnt to swim	
Basic – Basic strokes, only limited strokes beyond domestic swimming pool	
Good – Strong swimmer, able to swim confidently in a variety of water conditions	
Excellent – Very strong and confident, could swim 50 metres fully clothed	

Mountain Biking Skills

Please indicate your Childs mountain biking skills below:

Mountain Biking Skill	✓
Non-rider – Hasn't yet learnt to ride a bike	
Basic – Basic riding on flat ground only	
Good – Can ride on varied terrain, use gears and brakes effectively	
Excellent – Very strong and confident on all terrain including jumps and drops	

General Fitness

Please indicate your Childs general fitness below:

General Fitness	✓
Less than 1 hour of exercise or sport per week	
2-6 hours of exercise or sport per week	
7-14 hours of exercise or sport per week	
14+ hours of exercise or sport per week	

Teacher Medication Form

I, _____

(Your Name)

Give permission for medication to be administered to myself.

Name of Medication	Reason/Purpose for Medication	Instructions for Administering	Amounts	Times/day
Please Note: Container must be clearly marked with your name, dosage and instruction's for dispensing.				
In the unlikely event that you miss the allocated time, what steps would you like taken (e.g. administer medication straight away, call you, call Emergency Help)?				
1.				
2.				
3.				
4.				
5.				
Are you familiar with taking this medication?			YES	NO

I understand that, while Barrington Outdoor Education staff and instructors may be prepared to assist in this matter, the ultimate responsibility rests with myself.

Your Name	Your Signature	Date

Teacher Asthma Management Form

I, _____

Your Name)

Give permission for below plan to be followed for myself.

Preventer (if prescribed)	**Use**	**Times/day**
Reliever	**Use**	**Times/day**
Symptom controller (if prescribed)	**Use**	**Times/day**
Before exercise	**Use**	**Times/day**
Additional medication to be taken in the event of significant wheeze or cough	**Use**	**Times/day**
Emergency medication	**Use**	**Times/day**

Known Trigger Factors (please circle and add details if applicable)

Dust of any sort in sufficient quantities	Yes	No
Sudden change in temperature	Yes	No
Contact with animals	Yes	No
Grass and weed pollens, mould	Yes	No
Vigorous exercise	Yes	No
Atmospheric pollution	Yes	No

Other – Details No Yes Details: _____

Teacher Allergy Management Form

Your Name _____

What are you allergic to? _____

What are the signs and symptoms of the reaction? _____

Medication and treatment during an emergency attack? _____

Have you previously suffered from any of the following:

Localised reaction (Rash, itching, swelling)	Yes	No
A systemic reaction (Rash, itching, swelling)	Yes	No
An anaphylactic reaction (severe breathing problem, total body swell, emergency situation)	Yes	No
Have you been admitted to hospital due to allergies in the last 12 months	Yes	No
Is there a history of anaphylaxis in your family?	Yes	No
Has allergies interfered with participation in normal physical activities within the last 12 months?	Yes	No
Does you carry + take adrenaline (Epi-pen), when suffering an allergic reaction? **If YES you MUST bring their Epi-pen/Anapen on camp**	Yes	No