

## Children’s Camp Registration Form

Please note there are 3 sections to this form. Please ensure each section is completed, and return to the coordinator of this programme

**Name of Event**: Rotary Camp 2018

**Location**: YMCA Camp Adair, 2487 Hunua Rd, RD3 Papakura, Auckland 2583

**Start date**: Friday 11th May 2018

**Time**: 3.15pm approx

**Finish date**: Sunday 13th May 2018

**Time**: 2.30-3.00pm TBC

## Section 1: Parental Consent, Emergency Contacts and Risk Disclosure

To be completed by parent/caregiver of child

# Participant Information Form

**Name**:

**Address**:

**Telephone**:

**Mobile**:

**Email address**:

**Age/Date of Birth**:

# **Emergency Contact Details**

(please provide at least 2 sets of contact details)

**Contact 1: Emergency contact during the event:**

**Name**:

**Relationship**:

**Address**:

**Email**:

**Day phone**:

**Evening Phone**:

**Mobile**:

**Contact 2: alternative contact:**

**Name**:

**Relationship**:

**Address**:

**Email**:

**Day phone**:

**Evening Phone**:

**Mobile**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Eye Condition:

**Partially sighted**: Yes / No

**Totally Blind**: Yes / No

**Corrected visual acuity**: (if known)

**Does your child wear glasses**? Yes / No

**Contact lenses**: Yes / No

**How well does your child use the vision they have in everyday situations**? (e.g. getting around, steps, poor light conditions)

**Does your child use a cane**? Yes / No

**What format does your child prefer for receiving information**? (e.g. email, braille, text, CD, large print etc)

**Give details of any specialist equipment and technology used**: (e.g. CCTV, laptop, magnifier, iPad)

**Does your child need support with personal care**? Yes / No

**If yes please specify**:

**Does your child have a behaviour management plan or strategy at home or school**? Yes / No

**If yes please provide a copy or the name and contact details of the person or organisation who wrote this**:

# Special notes:

**To ensure we are able to take into account the needs of all individuals on this event please provide any other information regarding your child’s participation that we need to be aware of.** (e.g. cultural practices; anxiety about heights/darkness/small spaces; swimming ability; distance capable of walking)

**Does your child currently receive services from the Blind Foundation**? Yes / No

**If yes names of staff involved**:

**What is the name of your child’s Resource Teacher Vision (RTV)**?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Parental Consent

To be read and signed by parent/caregiver of child participant

I, the undersigned, have disclosed all necessary information to ensure my child’s safety and I agree to my child’s participation in this programme.

I understand that places are limited and that due to the nature of some activities additional specific selection criteria may apply for health and safety reasons. I understand that my child may not therefore be selected for participation on this occasion.

I agree that responsibility for safety is a 3 way partnership between participants, parents and staff running the event and that I will do my best to ensure that my child follows the instructions given by the Blind Foundation leader(s)

Should my child need to be returned home from camp for any reason, I understand that I will be responsible for arranging their safe return home.

I give my consent for my child to travel in vehicles driven by staff or volunteers, using approved seat belt restraints.

I give my consent for my child being involved in any publicity, including photographs.

The staff and volunteers will exercise all due care, but will be clear of all liability in the event of any injury, damage or loss my child may sustain to their person or property.

Any injuries or illness will in the first instance be attended by a staff member who is a first aider. I authorize that should qualified medical attention be required this will be secured at my expense and I will be promptly notified.

I understand that the Blind Foundation does not accept responsibility for loss or damage to personal property and that it is my responsibility to check my own insurance policy.

I have read the event information sheet and I understand that there may be risks associated with involvement in Blind Foundation events and that these risks cannot be completely eliminated. I understand that the Blind Foundation will identify any foreseeable risks or hazards and implement correct management procedures to eliminate, isolate or minimize those hazards. I understand my child will be involved in the development of safety procedures. I will do my best to ensure that my child follows these procedures.

I know that I am able to ask any questions about the activities my child will be involved in, to gain a better understanding of the risks involved. I recognize that participation in such activities is voluntary and not mandatory through a ‘challenge by choice’\* procedure. My child and I both understand that they may withdraw from an activity if they feel at risk. This must be done in consultation with the person in charge.

(To be read and signed (electronic signature) by parent/caregiver of the child participant)

**Name**:

**Signature**:

**Date**:

\*‘Challenge by choice’ means the participant chooses their own level of challenge within a supportive peer environment

## Section 2: Health profile and medical consent

(This section is designed to assist with the care of all participants on Blind Foundation programmes)

**Name of applicant**:

**Family Doctor**:

**Telephone**:

**Medic Alert Number (if applicable**):

**Community Services Card number**:

**Expiry date**:

# Medical/Health Conditions

Please indicate **yes or no** if your child has any of the following:

**Migraine**:

**Epilepsy**:

**Asthma**:

**Diabetes**:

**Travel sickness**:

**Seizures of any type**:

**Heart condition**:

**Dizzy spells**:

**Colour blindness**:

**ADHD**:

**Sleep walking**:

**Bedwetting**:

**Chronic nose bleeds**:

**Other**:

**Is your child currently taking medication**? Yes / No

**If yes please state name/s of health condition/s**:

**Name of medication/s**:

**Dosage and time/s to be taken**:

**Is this self-administered**? Yes / No

If no, I agree to staff supervision of medication. Please complete the additional medication form attached for staff to sign

**Has your child had any major injuries (breaks or strains) or illness (glandular fever etc) in the last six months that may limit full participation in any activities**? Yes / No

**If yes, please state the injury/illness**:

**To the best of your knowledge has your child been in contact with any contagious or infectious diseases in the last four weeks**? Yes / No

**If YES, please state or attach information**:

**Is your child allergic to any of the following** (please indicate yes or no)?

**Prescription medication**:

**Food**:

**Insect bites/stings**:

**Other allergies**?

**What treatment is required**?

**When was your child’s last tetanus injection**?

**What pain/or other medication may your child be given if necessary**?

**Outline any dietary requirements**:

**Is there any other information the Blind Foundation should know to ensure the physical and emotional safety of your child**? Yes / No

**If YES please state or attach information**:

# Declaration:

I agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened and handed to the designated adult with instructions on its administration. I have also completed and submitted the Blind Foundation medication form.

I will inform the Blind Foundation programme coordinator as soon as possible of any changes in the medical or other circumstances between now and the commencement of the programme

I understand that any injuries or illness will in the first instance be attended by a Blind Foundation staff member trained in first aid. I agree to my child receiving any emergency medical, dental, or surgical treatment as may be considered necessary by the medical authorities, that this will be secured at my expense and that I will be promptly notified.

If my child is involved in a serious disciplinary problem, including the use of illegal substances and/or alcohol, or actions that threaten the safety of others, s/he will be sent home at my expense.

(To be read and signed (electronic signature) by parent/caregiver of the child participant)

**Signature**:

**Name**:

**Date**:

## Section 3: Student Contract – to be supported by parent/caregiver when completing below

**Name of applicant**:

**Have you previously attended a programme similar to this**? Yes / No

**If yes, please supply details**:

**What activities are you currently involved in**?

**What would you like to achieve from attending this programme**?

**Declaration**

I understand that this programme is an opportunity for me to learn, practise skills and gain attitudes and values in an environment outside the classroom. I realise that this requires me to take on genuine responsibility for my own learning and safety, and that of others.

I agree to do the following to make this happen:

Show courtesy and consideration to others

Follow the rules and instructions of activity leaders and assistants at the programme, including during travel

Take part in all activities within the challenge-by-choice \* options

Look after myself and my personal belongings

Declare medical conditions that could affect participation in this programme

Accept the rules set by the Blind Foundation, even if they are different from what is accepted at home

I understand that my parents/caregivers will be contacted and I may be sent home at their expense if:

My actions are considered unacceptable by staff

I breach the no drugs and alcohol policy of the Blind Foundation

My actions put me or others in any danger

**Applicant**:

**Date**:

If this section was not completed by the applicant, please note the name of the writer

\*’Challenge by choice’ means the participant chooses their own level of challenge within a supportive peer environment

|  |  |
| --- | --- |
| Date received |  |
| Date payment received |  |
| Method of payment |  |