KORMILDA COLLEGE SONY FOUNDATION
CHILDREN'S HOLIDAY CAMP 2017

Please attach child's photo

Initial Information Package

(To be completed by Parent/Guardian/Carer/Teacher)

Child's Surname _____

First Name _____

Date of Birth _____ Age _____

Height _____ Weight _____

Child's Disability

_____

Email address

_____

Current School _____ Grade _____

Teacher _____

Parent/Guardian Name and Address Telephone numbers: Home: _____ Work: _____ Mobile: _____ _____	Does the child live at this address *(Please circle)* YES / NO If NO, please state usual residential address

Name of person recommending child _____

Relationship to child _____

Contact number _____

Reason for recommendation _____

_____

Routine Medications

State Medication Name / Dose / Times given

Name Dose Times given	Name Dose Times given	Name Dose Times given
Name Dose Times given	Name Dose Times given	Name Dose Times given

Allergies

Food _eg. Peanuts_____

Medication _eg. Penicillin_____

Other _eg.latex_____

If Yes to any of the above, **please complete the attached Allergic Reaction Form**

Has your child ever been treated for ASTHMA? YES / NO
If yes, **please complete the attached Asthma Form**

Has your child ever been treated for EPILEPSY? YES / NO
If yes, **please complete the attached Epilepsy Form**

Any other medical problems, special and/or current treatments we should be aware of?

_____

_____

Respite

Please circle the regular respite or support assistance you receive:

Daily / Weekly / Monthly

Discuss the type of respite you receive _____

_____

Care Plan

(Please give detailed information)

About your Child

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

Quiet / Active / Very Active
(Please circle)

Favourite hobbies _____

_____

Favourite toys _____

_____

Any brothers and/or sisters _____

_____

People whose company your child enjoys _____

_____

Favourite topics of conversation _____

_____

Any pets _____

_____

Sports teams – cricket, football, *etc* _____

_____

Communication

(please circle your child's ability to communicate)

1	2	3	4	5
difficult to understand				*very clear and easy to understand*

What are the best methods of communicating with your child?

_____

_____

How much of what is being said can your child understand?

_____

_____

Mobility

Does your child require assistance or aids to walking? YES / NO

If yes, please explain

_____

_____

Does your child need a wheelchair? YES / NO

If yes is the chair **manual** or **motorised**? _____

When does your child use the chair?

_____

Does your child need assistance transferring? YES / NO

Does your child need routine physiotherapy or exercise regimes? YES / NO

If yes please describe _____

_____

Diet and Eating

How meals should be provided?

Normal Cut up Puréed Special Diet Other
(Please circle)

Small Medium Large
(Please circle)

If **Special Diet** or **Other**, please explain _____

_____

_____

Is there a problem with aspirating during meals/feeds? If so, how do you prevent it?

_____

How do you manage aspiration when it occurs? _____

_____

Is assistance required with meals? YES / NO

If yes please comment on assistance required, i.e. positioning, special utensils:

_____

_____

Does your child have a **Gastrostomy**? YES / NO

If YES please complete the following

Are they **Nil by Mouth**? _____

Do they eat food? _____

Do they drink fluids? _____

When are feed times? _____

What formula is used and how is it made? _____

_____

How is formula given and over how long? _____

_____

Describe the equipment cleaning routine? _____

_____

Toileting

Does your child wear incontinence aids? YES / NO

If so please describe size, type and frequency of changing _____

_____

Is assistance required with toileting? YES / NO

If so please describe _____

_____

What is your child's normal toileting routine and pattern? _____

_____

_____

How regularly does your child open their bowels? _____

_____

Does your child use aids? E.g. a special chair _____

_____

Personal Hygiene

Can your child dress themselves? YES / NO

How can we make dressing easier for your child? _____

_____

What is your child's preference for daily showering? _____

_____

Describe the methods your child uses for oral hygiene? _____

_____

Sleeping

Usual waking time _____ Usual settling time _____

Usual settling routine _____

_____

Does your child wake during the night? YES / NO

If yes, how do you settle them back to sleep? _____

Do they need bedrails? YES / NO

Is any sleeping aid required? _____

Preferred sleeping position: _____

Swimming

Please circle your child's swimming ability and needs

- Very competent swimmer in deep water
- Swims unaided
- Requires floatation device
- Does not like swimming
- Requires more than one assistant for support in the water

Describe how your child swims (stroke type, floats only, etc) _____

_____

Does your child wear incontinence protection when swimming? YES / NO

Behavioural Support

Please describe the methods you use to help your child manage situations of difficult behaviour

1. At home _____
2. At school _____
3. On outings _____

Any Other Relevant Information

_____

Medical Details

Child's name: _____ Dob: _____

Medicare number: __ __ __ __ __ __ __ __ __ __ __ Expiry date ___ / ___

Emergency Contact Information

Emergency Contact 1

Name _____

Relationship to child _____

Address _____

Postal Address _____

Telephone numbers _____

Emergency Contact 2

Name _____

Relationship to child _____

Address _____

Telephone numbers _____

Emergency Contact 3

Name _____

Relationship to child _____

Address _____

Telephone numbers _____

Allergies

FOOD	MEDICATION	OTHER
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Conditions

(Please tick)

- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Other

(please complete relevant form if yes to any of the above medical conditions)

Past Illnesses

(Please tick)

- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Glandular Fever
- ☐ Fainting
- ☐ Other
- ☐ Hepatitis
- ☐ Head Injuries
- ☐ Rheumatic Fever

Other past medical conditions

_____

_____

_____

Past operations, please also state year of operation

_____

_____

_____

Are immunisations current for age? YES / NO

Please supply copy of immunisation record.

Camp Procedures in the Event of an Accident or Illness

Ailments and minor injuries

- The registered Nurse on duty will assess any ailment or injury as appropriate should they arise. If deemed appropriate referral may be made to other health professionals and parent.

Serious ailments/injuries requiring doctor or hospital admission

- Parent/guardian will be contacted using details on the Emergency contacts form.
- First aid will be initiated by staff member in attendance and the Registered Nurse will assess camper.
- The nurse will decide if the student should be taken to hospital immediately or a doctor contacted.
- In an emergency or on the advice of a doctor, the camper will be transferred by ambulance to hospital. A Kormilda College representative will stay with the patient until relatives attend the hospital.

Medications

It is imperative that camp staff are made aware of all medications taken by campers

The following non-prescription medications are held in the School Clinic for the treatment of minor conditions and illnesses. Please **initial beside each medication** which **you authorise** nursing staff to administer to your child if required

Panadol ……..	Mylanta …….
Nurofen ……	Stingose …….
Aspalgin ……..	Aspirin ……..
Sudafed ……	Visine eye drops ……..

Anti-inflammatory gels …… Cold sore cream ……

Throat gargles …….. Throat lozenges …….

Gastrolyte ……. Lasonil cream for bruises …….

For the relief of minor allergies the following medications may be given. No medication will be given without this authority except in an emergency. Please **initial beside each medication** which **you authorise** nursing staff to administer to your child if required.

Claratyne …… Phenergan ……...

Medications to be held at the camp at parents request:

_____

_____

_____

Medical Consent

I/We provide the information contained in this form and consent to the procedure set out being followed in the event of injury or illness of _____

In particular I/we authorise you to obtain and assist in the administration of medications specified and any others s notified by me/us

_____ _____

(Signature parent/guardian) *(Date)*

Consent to Release of Information

Due to the numbers of children wishing to attend the camp, it may be necessary for us to contact your child's school to obtain information to support your application. Please complete the following authorisation to access information.

I _____ _____

(Parent/guardian name) *(Relationship to child)*

give permission for the Nurse or Registrar from the Kormilda College Sony Foundation Children's Holiday Camp to contact _____ to obtain information that will assist in the care of my child _____

_____ _____

(Signature and name) *(Date)*

Telephone numbers: _____

Consent to Photographs and Publicity

I understand that photographs and video footage will be taken over the duration of the camp and give permission as follows (please tick yes/no below) for any photographs or video footage of my child to be used on:

YES	NO	
☐	☐	a CD that will be given to all camp participants
YES	NO	
☐	☐	a CD that will be given to the Sony Foundation, the major sponsor of this camp, to assist them in further fundraising for future camps
YES	NO	
☐	☐	for use in Kormilda College publications that recognises the input of our Student Carers
YES	NO	
☐	☐	for promotional publicity of the camp or College through media, including the College website