NCIE June-July School Holiday Program- ENROL NOW!

The NCIE
The National Centre of Indigenous Excellence provides a culturally safe space for young people to immerse themselves in Indigenous culture. Through our state of the art facilities, we are able to offer activities across our four pathways: Art’s Culture; Learning & Innovation; Health & Wellness; and Sports & Recreation.

The Program
The School Holiday Program provides a range of recreational and educational activities. Our engaging and interactive program facilitates the growth and development of all young people between the ages of 6 and 14 years old. Places are limited and will be allocated to those who register early.

The School Holiday Program provides high-quality care with engaging and stimulating activities which means you can relax, knowing your child is in a safe and encouraging environment that inspires creativity.

Dates: The Program runs from Monday the 30th June to Friday 4th of July. You can enroll child(ren) for one day or the entire duration of the program.

Cost: 10 places per day are offered free to Aboriginal and Torres Strait Islander families that are in financial hardship. Payment is due in advance on the first day of program at the front desk of NCIE.
In order to secure your place, please confirm which days your child(ren) will be attending

<table>
<thead>
<tr>
<th></th>
<th>MON (30th)</th>
<th>TUE (1st)</th>
<th>WED (2nd)</th>
<th>THU (3rd)</th>
<th>FRI (4th)</th>
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<tbody>
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**TERMS & CONDITIONS**

1. The School Holiday Program (SHP) is operated by National Centre of Indigenous Excellence employees and volunteers.
2. If your child is not able to attend on a given day where you have indicated previously that they would, you must notify staff as soon as possible by calling 0428 032 343.
3. **Drop off is 8:30 to 9:00am and pick up is 4:30 to 5:00pm** unless otherwise notified by staff. Failure to adhere to these times may result in your child not being allowed to participate in the SHP.
4. Phones or handheld electronic devices are not permitted during the SHP. If a child needs to contact a parent or guardian during the SHP, you must notify staff at drop off.
5. Morning and afternoon snacks will be provided however lunch is not provided. **You must pack lunch for your child(ren).** Nuts or products containing nuts are strictly prohibited.
6. Staff may carry out the SHP activities off site - please refer to the program of activities. You hereby accept that they may leave the premises to partake in these supervised activities offsite.
7. The National Centre of Indigenous Excellence Ltd do not accept liability for personal injury, property damage or loss sustained by a participant as a result of his or her participation in the SHP unless caused by the proven negligence of the NCIE, its directors or employees.
8. Photographs of the participants may be taken during the SHP. You hereby authorise the use of these photos for publicity and advertising purposes of the National Centre of Indigenous Excellence Ltd.
9. Participants must maintain good behaviour. The following list is an example of unacceptable behaviour and in this instance may be asked to leave the SHP at the sole discretion of staff:
   - SWARING / RAISING YOUR VOICE
   - DISCRIMINATION
   - INTIMIDATION / BULLYING
   - STEALING
   - DAMAGING OF EQUIPMENT / PROPERTY
   - RIDING BIKES, SCOOTERS OR SKATEBOARDS INSIDE
   - SPITTING
   - THROWING THINGS

Please acknowledge that you have read and understood the terms & conditions herein:

_____________________________  ___________________________  __________
NAME  SIGN  DATE
The purpose of this form is to help us adequately prepare for your child's participation in NCIE programs. This information is confidential and students will not normally be excluded for medical reasons. By providing accurate information you are ensuring your child's safety and wellbeing.

**SCHOOL:** _________________________________________ **Year:** ______

**STUDENT’S NAME:** _______________________________ **D.O.B:** ____/____/______ **Male □ Female □**

**Parent or Guardian – Primary Emergency Contact:**

Name: __________________________ **Relationship:** __________________________
Email: __________________________

**Phone:** (Home): ___________ (Work): ___________ (Mobile): ___________

Medicare No: □□□□□□□□□ □ **Valid to:** ___________

Doctor’s Name: __________________________ **Telephone:** __________________________

Are you a member of the Redfern Aboriginal Medical Service (AMS)? □ YES □ NO

<table>
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<tr>
<th>MEDICAL HISTORY</th>
<th>Please tick either Yes or No to all Questions</th>
<th>Provide detailed information: How serious is it? What is it? When? Has it fully recovered? Any known triggers? Is it self managed? Anticipated special management needed?</th>
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<tr>
<td>Asthma</td>
<td>[ ] No [ ] Yes</td>
<td>If YES, complete the “Asthma Management Form”</td>
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<tr>
<td>Allergies</td>
<td>[ ] No [ ] Yes</td>
<td>If YES, complete the “Allergenic Reaction Management Form”</td>
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<tr>
<td>Diabetes</td>
<td>[ ] No [ ] Yes</td>
<td>If YES attach current management/care plan. A fitness to participate form signed by treating doctor will also be required.</td>
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<tr>
<td>Epilepsy</td>
<td>[ ] No [ ] Yes</td>
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<td>Joint/muscle/bone problems?</td>
<td>[ ] No [ ] Yes</td>
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<tr>
<td>Sight/hearing impairment</td>
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<td>Any serious injuries/illness in the last 12 months?</td>
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<tr>
<td>Is your child currently on any medications?</td>
<td>[ ] No [ ] Yes</td>
<td>Please name the medication and dosage</td>
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<td>Other medical condition that may affect participation?</td>
<td>[ ] No [ ] Yes</td>
<td>Any health issue that require attention or special care?</td>
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Email: __________________________

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Medicare No: □□□□□□□□□ □ **Valid to:** ___________

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CARRIAGEWOKRS
Other: learning issues, psychological, emotional or behavioural issues? [ ] No [ ] Yes

Please add details to assist in understanding and managing the student

DIETARY
Any special requirements? [ ] No [ ] Yes

If vegetarian, does your child eat fish or white meat?

SWIMMING ABILITY
My child can swim 50 metres [ ] No [ ] with a struggle [ ] Comfortably [ ] Strongly

I declare that the information which I have provided on this form is complete and correct and that I will notify the school if any changes occur. I authorise the teacher or any employee of NCIE who is with my child, to give consent where it is impractical to communicate with me, and agree to my child receiving such medical or surgical treatment as may be deemed necessary. I give permission for NCIE to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment of my child. I give permission for NCIE to retain this form for statutory archival requirements

Signed: _____________________________________________ (Parent/Guardian) Date: ___________________

Photograph Consent

I consent to my child being photographed and/or visual images of my child being taken during activities, for use in NCIE publications, on the NCIE website, or for publicity purposes without acknowledgment and without being entitled to any remuneration or compensation and photograph my child or children at the NCIE. I understand that NCIE might use the recordings or photographs to talk about their work in communities in all types of media (radio, newspapers, website etc.). I understand that the recordings/photographs may be adapted, reproduced, modified, stored and used by NCIE and people that it nominates to promote the work that it does. The NCIE may reproduce the recordings and materials in any form, as a whole or in part, and distribute them through any medium that it thinks is appropriate. I accept that my child/children will receive no payment. I understand that they do not have to be recorded or photographed.

I consent to my child/children being recorded and photographed by NCIE. (Please strike out this sentence if you do not agree)
Asthma Management Form

Participant’s Name: 

Name of doctor treating the participant for this condition: 

Doctor’s Contact Phone Number: 

1) USUAL ASTHMA ACTION PLAN

Usual signs of participant’s asthma:

- Wheeze
- Tight Chest
- Cough
- Difficulty breathing
- Difficulty talking
- Other (please describe) ___________________

Signs participant’s asthma is getting worse:

- Wheeze
- Tight Chest
- Cough
- Difficulty breathing
- Difficulty talking
- Other (please describe) ___________________

Participant’s Asthma Triggers:

- Cold/flu
- Exercise
- Smoke
- Pollens
- Dust
- Other (please describe) ___________________
**ASTHMA MEDICATION REQUIREMENTS** (Including relievers, preventers, symptom controllers, combination)

<table>
<thead>
<tr>
<th>Name of Medication (e.g. Ventolin, Flixotide)</th>
<th>Method (e.g. puffer &amp; spacer, turbuhaler)</th>
<th>When and how much? (e.g. 1 puff in morning and night,)</th>
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Does the participant need assistance taking their medication? Yes [ ] No [ ] If yes, how? __________________________________________

Any other information that will assist with the asthma management of the participant while on Program?

- e.g. peak expiratory flow or recent attacks

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**OR**

**Participant’s Asthma First Aid Plan** (if different from above)

- In the event of an asthma attack, I agree to the participant receiving the treatment described above.
- Notify in writing if there are any changes to these instructions.

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<th>YES [ ]</th>
<th>YES [ ]</th>
<th>YES [ ]</th>
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<td>Has asthma interfered with participation in physical exercise within the past 12 months</td>
<td>NO [ ]</td>
<td>YES [ ]</td>
<td></td>
</tr>
<tr>
<td>Has the participant required hospitalization due to asthma in the past 12 months?</td>
<td>NO [ ]</td>
<td>YES [ ]</td>
<td></td>
</tr>
<tr>
<td>Has the participant been on oral cortisone for asthma within the past 12 months (e.g. Prednisone, Cortisone, etc)?</td>
<td>NO [ ]</td>
<td>YES [ ]</td>
<td></td>
</tr>
<tr>
<td>Has the participant suffered sudden severe asthma attacks requiring hospitalisation within the past 12 months?</td>
<td>NO [ ]</td>
<td>YES [ ]</td>
<td></td>
</tr>
<tr>
<td>Does the participant require the use of a nebulising pump as a part of your regular or emergency asthma treatment?</td>
<td>NO [ ]</td>
<td>YES [ ]</td>
<td></td>
</tr>
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</table>
1) IMPORTANT NOTES

If any of the “KEY QUESTIONS” a, b, c, d, or e above are answered “Yes”, the decision for the participant to attend rests with their Doctor. A “Fitness to Participate” form must be completed by the Doctor (attached). Please bring this form to the Doctor with you.

The Fitness to Participate form should be attached to the medical and asthma management forms and returned to the NCIE.

I declare that the information provided on this form is complete and correct and that I will notify the NCIE if any changes occur. I further declare that if my child (or I for adults) is unable to self administer supplied medication, I give permission for trained NCIE staff to administer the supplied emergency medication. I give permission for NCIE to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment of my child (or myself for adults). I give permission for NCIE to retain this form for statutory archival requirements.

Name: __________________________ Signature: __________________________ Date: __________________________

Allergenic Reaction Management Form

If necessary, seek the advice of your doctor when completing this form.

A DOUBLE DOSE OF ALL MEDICATION REQUIRED FOR THE PARTICIPANT’S ALLERGIC REACTION, MUST BE BROUGHT INTO THE NCIE AND NOTED ON THE MEDICAL FORM. E.g. (if Epi-Pens or any other type of Auto Injector is required 2x must be supplied and bought on program)

Student’s Name: __________________________ Name of doctor treating the student for this condition: __________________________

Doctor’s Contact Phone Number: __________________________

1. What is the student allergic to?

Bites: □ Foods: □ Medications: □ Stings: □ Other: □

Please Specify: __________________________

2. What are signs and symptoms of the person’s reaction?

□ Low - a localised reaction (rash, itching, swelling at the site the poison/irritant enters)

□ Moderate - a systemic reaction (rash, itching, swelling away from the site that poison/irritant enters)

□ Severe - an anaphylactic reaction (severe breathing problem, total body swell, emergency situation)

Please give details: __________________________
3. What medication does the participant take (if any) for their allergic reaction?

4. Medication and treatment to be used during emergency situations:

"KEY QUESTIONS"

5. Has the participant required hospitalisation due to allergies in the past 12 months? [ ] NO [ ] YES

6. Has the participant suffered a systemic or an anaphylactic reaction (see question 2 for definition), to their allergy when triggered in the last 10 years? [ ] NO [ ] YES

7. Does the person take, or has the person been prescribed, adrenaline (Epi-pen or similar), when suffering an allergic reaction? [ ] NO [ ] YES

IMPORTANT NOTES:

If any of the "KEY QUESTIONS" 5, 6 or 7 above are answered "Yes", the decision for the participant to attend rests with their Doctor. A "Fitness to Participate" form must be completed by the Doctor (attached). Please bring this form to the Doctor with you.

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Name: __________________________ Signature: __________________________ Date: __________________________
Fitness to Participate Form

School Name: _____________________________  Year Level: ____________

Name of Participant: _________________________  D.O.B. ______________________________

Specific Medical Condition: (e.g. Asthma, Allergies) ______________________________________

Notes to treating Doctor
This patient is scheduled to participate in an NCIE program and has self-identified a pre-existing medical
condition on their medical form.

Meaning that professional medical care may be from 1 to 3 hours away. All programs include regular physical
exercise.
(Should you require any further information on the program, please contact the NCIE Program Coordinator.

NCIE staff hold First Aid qualifications

Doctor to complete:

Based on this information above and the patient’s condition, we ask that you decide on this person’s
suitability to participate in the upcoming program. If approved, please include specific treatment
protocols to follow in the event of an emergency.

Do you approve this participant attending an NCIE program, based on their current medical
condition, coupled with the demands of the program?

☐ Yes  ☐ No

What treatment protocol are you willing to authorize for this patient in the case of a medical
emergency, in a remote location (i.e. one or three more hours away from medical care)?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

________________________________________________________________________________
What should the NCIE staff managing this participant in the field be informed/ aware of, in regards to the particular situation for this patient? What are the recommended parameters for participation in the activities?

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

Name of Doctor: ___________________________ Phone: _________________________

Signature of Doctor: ______________________ Date: ____________________________

School Holiday Program Contact Details

April Long
Programs Manager
April.long@ncie.org.au
Mobile: 0412 206 205

Felicity Canham
Programs Coordinator
Felicity.canham@ncie.org.au
Mobile: 0428 032 343

Please return forms by 16th June 2014