**CONSENT TO PARTICIPATE**

***Consent to participate in programs, activities and events (without parental attendance)***

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| --- | --- |
| **ACTIVITY** | |
| Description of program/activity or event |  |
| Location/venue |  |
| Start time and end time |  |
| Transportation arrangements |  |
| Food and refreshement provision |  |
| Dress code (eg. outdoor adventure activities) |  |
| Safe participation information (eg. access to venue) |  |
| Equipment requirement (eg. sunscreen, hat, water bottle) |  |
| Supervision arrangements (eg. including names of  supervising adults) |  |
| Pick up arrangements |  |
| RSVP date |  |

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| **CHILD OR YOUNG PERSON’S DETAILS** | |
| Last name |  |
| First name |  |
| Date of birth | ……………………../……………………./………………… (day/year/month) |
| Age |  |
| Gender |  |
| Does the child or young person identity as Aboriginal or  Torres Strait Islander?  (Optional) | 🞏 Yes  🞏 No |
| Is the child or young person from a culturally and linguistically diverse background  (Optional) | 🞏 Yes  🞏 No  If “yes”, what languages(s) are spoken at home? |
| Does the child or young person have a disability or additional support needs, eg. medical? | 🞏 Yes  🞏 No  If “yes", please provide information in relation to your child's health and/or additional support needs |
|  | |
| **PARENTAL AND/OR CARER CONTACT INFORMATION** | |
| **Parent/carer 1** |  |
| Last name |  |
| First name |  |
| Address |  |
| Telephone | Home |
|  | Work |
|  | Mobile |
| Email address |  |

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| --- | --- |
| **Parent/carer 2** |  |
| Last name |  |
| First name |  |
| Address |  |
| Telephone | Home |
|  | Work |
|  | Mobile |
| Email address |  |
| **Nominated emergency contact 1** | |
| Last name |  |
| First name |  |
| Address |  |
| Telephone | Home |
|  | Work |
|  | Mobile |
| Relationship to the child/young person |  |
| **Nominated emergency contact 2** | |
| Last name |  |
| First name |  |
| Address |  |
| Telephone | Home |
|  | Work |
|  | Mobile |
| Relationship to the child/young person |  |

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| **MEDICAL AND/OR ADDITIONAL SUPPORT INFORMATION** | | |
| **Medical Practitioner – emergency contact information** | | |
| Last name | |  |
| First name | |  |
| Clinic | |  |
| Address | |  |
| Telephone | | Contact |
|  | | Mobile |
| Email address | |  |
| **Please provide any medical and/or additional support information to support your child's safe participation in this program/activity/event.**  **For example: Asthma management plan, diabetes, food allergy and intolerances, anaphylaxis management plan, disability support** | | |
|  | | |
| 🞏 | I have attached a documented plan to support any medical and/or additional support needs of my child | |

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| **MEDICATION DETAILS** | |
| 🞏 | I have provided *insert child/young person’s name]*  with medication (in original packaging) and consumables required to administer the medication including a dosage pharmacy information label to ensure that my child is provided with medication when required. |
| 🞏 | My child is able to manage their own health condition and has my permission to carry and self-administer their medication. |
| **MEDICATIONS**  ***Medication 1:***  Name of medication *(please print)*  Dosage *(please print)*  Storage requirements *(please print)*  Special instructions for administering medication  .....................................................................................................................*(please print)*  Expiry date of medication *(please print)*  ***Medication 2:***  Name of medication *(please print)*  Dosage *(please print)*  Storage requirements *(please print)*  Special instructions for administering medication  .....................................................................................................................*(please print)*  Expiry date of medication *(please print*) | |
|  | |
| **PROVISION OF MEDICAL TREATMENT** | |
| In the event that you are unable to communicate with me (or my nominated emergency contacts), I consent to my child receiving such medical or surgical treatment as may be deemed necessary and I agree that any such treatment will be at my expense. | |

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| **PARENT OR GUARDIAN PERMISSION** |
| I, *[parent/guardian's name]*  consent to my child *[child/young person's name]*  attending *[name of program]*  from……........................................*[start time & date]* to *end time & date]*  Signature of parent/guardian  Name of parent/guardian  Address    Home phone .........................................................Mobile phone: ............................................................  Email  Date |
|  |
| **CHILD OR YOUNG PERSON CONSENT TO PARTICIPATE** |
| I,……..............................................................................................................*[child/young person's name]*  consent to participate in  Signature of child/young person  Name of child/young person  Address .    Home phone .........................................................Mobile phone:  Date |
|  |
| **CONSENT TO USE CHILD/YOUNG PERSON’S IMAGE** |
| I, *[parent/guardian's name]*  consent to a photograph or video image of my child/young person  *[insert child/young person’s name]* being used without acknowledgement, remuneration or compensation, in publications (print, websites, DVDs, CDs, ROMs, etc.) and/or presentations of the Catholic Diocese of Ballarat and in particular in  *[name of publication/presentation]*  Signature of parent/guardian  Relationship to child/young person |