Active After-school Communities
Participation and Research Consent Form - Parent\Guardian

School \ Out of School Hours Care Service (OSHCS) details:

School or OSHCS Name

Activity(s) being delivered | Term | | Activities |

Child/ren details: *To be completed by Parent\Guardian. PLEASE USE CAPITALS*

*Please include **all children** who are participating in the Active After-school Communities Program this term.*

Child 1

First name | **Last name** | **Sex** *(circle one)* M F

Date of birth | **Is child of Aboriginal or Torres Strait Islander origin?** *(circle one)* Yes No | **School Year** *(eg Year 4)*

Child 2

First name | **Last name** | **Sex** *(circle one)* M F

Date of birth | **Is child of Aboriginal or Torres Strait Islander origin?** *(circle one)* Yes No | **School Year** *(eg Year 4)*

Child 3

First name | **Last name** | **Sex** *(circle one)* M F

Date of birth | **Is child of Aboriginal or Torres Strait Islander origin?** *(circle one)* Yes No | **School Year** *(eg Year 4)*

Parent\Guardian details: *To be completed by Parent\Guardian. PLEASE USE CAPITALS*

Parent\Guardian first name | **Parent\Guardian last name** | **Relationship to the child/ren**

Does your household speak any languages other than English at home? *(circle one)* Yes No | **If yes, what other languages?**

Postal address

Suburb/town | **Postcode** | **State/Territory**

Home landline phone number ( )

Work landline phone number *(if applicable)* ( )

Mobile phone number *(if applicable)*

Please turn over

Consent\Authority to participate in the Active After-school Communities Program:

1. As the parent or legal guardian of the child/ren named above (**my child/ren**), I give my permission for my child/ren to participate in the Active After-school Communities program (**"Active After-school" program**) activities specified above, to be conducted by the School\OSHCS named above.
2. I agree to release the Australian Sports Commission (**ASC**) from any liability to my child/ren or myself in relation to any injury or illness that my child/ren may suffer, and for loss or damage to property, in connection with the activities, except to the extent that liability arises as a result of the negligence of the ASC.
3. I acknowledge and agree that the School\OSHCS collects personal information for the purposes of conducting the activities, and that the School\OSHCS may provide this personal information to the ASC for the purposes of the ASC administering, evaluating and reporting on the "Active After-school" program.
4. I give my permission to the supervisors of the activities appointed by the School\OSHCS to implement the School\OSHCS code of conduct and\or take other reasonable measures to ensure the successful conduct of the activities and safety and well-being of the activity participants.
5. In the event of any injury or illness to my child/ren, I authorise the supervisors to apply or arrange first aid and to arrange examination by a registered medical practitioner and, if contact with me is impracticable or impossible, to arrange whatever medical treatment the registered medical practitioner considers necessary at that time. I will pay all medical expenses incurred on behalf of my child/ren.
6. I have provided all information necessary for the supervisors to plan safe participation by my child/ren in the activities, including, if relevant, details of any activities that my child/ren should not participate in or that should be modified for my child/ren due to medical or other reasons.

Consent\Authority to participate in the Active After-school Communities Program Evaluation:

7. The ASC is undertaking an **evaluation** of the "Active After-school" program and will need to gather the views of those involved in the "Active After-school" program, including participating children and their parents\guardians. The ASC and its contracted researchers **may contact you in the future to invite you to participate in a telephone interview that could take about 15 minutes of your time.** The interview may ask you about the types of physical activity your child/ren takes part in, how your child/ren feels about physical activity, what kind of impact the "Active After-school" program has had on your child/ren, and/or how you feel about the "Active After-school" Program.
8. Involvement in the telephone survey is voluntary. Participants will be randomly selected. All responses will be kept confidential and any reporting will be generalised so that no one individual can be identified.

If you tick the box below to indicate that you do grant permission, the details you provide on this form may be passed on to the ASC and its contracted researchers for the above research with parents/guardians.

I **GRANT** permission ..... ☐

I have read, understood and agree to the above terms and conditions.

Name _____

Signed _____

Date _____

Asthma FOUNDATION

Child Asthma Record

This form is to be completed by parents/carers, ideally in consultation with the child's doctor (general practitioner or specialist). Parents/carers should inform the service immediately if there are any changes to the child's asthma management. A new Asthma Record should be provided at the beginning of each year.
Please tick the appropriate box, and print your answers clearly in the blank spaces where indicated.

Personal Details

Child's Name _____ (first name) _____ (last name)

Gender ☐ Male ☐ Female Date of Birth __ __ / __ __ / __ __ __ __

Emergency Contacts (eg. Parent or Carer)
1. Name _____ Relationship _____
Telephone (daytime) _____ (home) _____
2. Name _____ Relationship _____
Telephone (daytime) _____ (home) _____

Doctor's Contact Details Name _____ Telephone _____

Asthma Management Plan

Does the child tell the carer when he/she needs medication? ☐ Yes ☐ No

Child's Symptoms (eg cough) _____

Triggers (eg exercise, pollens) _____

Medication Requirements: (Parents need to supply asthma medication eg, puffer and spacer)

Name of Medication	Method of delivery (eg puffer & spacer)	When & How Much

In an **EMERGENCY**, follow the plan that has been ticked:

☐ **Standard Asthma First Aid Plan**

Step 1: Sit the child upright and remain calm and provide reassurance. Do not leave the child alone.

Step 2: Give 4 puffs of a blue reliever (*Airomir, Asmol, Epaq or Ventolin*), one puff at a time, through a spacer device*. Ask the child to take 4 breaths from the spacer after each puff.

Step 3: Wait 4 minutes.

Step 4: If there is little or no improvement, repeat steps 2 and 3. If there is still little or no improvement, call an ambulance immediately (Dial 000). Continue to repeat steps 2 and 3 while waiting for the ambulance.

*Use a blue reliever (*Airomir, Asmol, Epaq or Ventolin*) on its own if no spacer is available.

☐ **My Child's Asthma First Aid Plan**

As written in consultation with my child's doctor.
(Full details must be attached or staff will use the Standard Asthma First Aid Plan)

Additional Comments: _____

_____

I authorise the staff at the service to follow the preferred Asthma First Aid Plan and assist my child with taking asthma medication should he/she require help. I will notify you in writing if there are any changes to these instructions.
Please contact me if my child requires emergency treatment or if my child regularly has asthma symptoms whilst attending the service.

Signature of Parent/Carer _____ Date _____

Signature of Child's Doctor (recommended) _____ Date _____