



## SUNSHINE COAST REPRESENTATIVE SCHOOL SPORT TEAM MEMBER CONSENT AND AGREEMENT

### Privacy Statement:

The Department of Education is collecting personal information of parents of state school and non-state school students, and any other persons in attendance, in accordance with the information privacy principals prescribed under the *Information Privacy Act 2009 (Qld)*, in order to record the details of parents and any other persons attending sporting events, to enable the department to comply with its obligations under the *Public Health Act 2005 (Qld)* and *Disaster Management Act 2003 (Qld)*. This information will only be accessed by authorised staff within the department. Your personal information will not be given to any other person or agency without your permission or where we are required by law.

<b>Student name:</b>		<b>Date of birth:</b>	
<b>School:</b>		<b>Gender:</b>	Male    Female
<b>Regional sport team:</b>			
<p>I accept the invitation for my child named above, to be a regional team member in the above regional sport team. I hereby give consent for my child to take part in any activity arranged by, or participated in, by Queensland Representative School Sport. I also give my permission for my child to use such forms of transport (if applicable).</p> <p>I agree:</p> <ol style="list-style-type: none"> <li>1. That my child, in accepting a position in the Sunshine Coast representative sport team, will commit to full participation in the team's program, including attending training sessions and participating in the state championship event.</li> <li>2. That during all activities leading up to, and during the state championship event, including any travel (if applicable), my child shall be under the sole direction of the person or persons appointed as team officials of the regional representative team in which they are included.</li> <li>3. To meet the costs associated with participation in this activity.</li> </ol> <p>I have read the code of conduct and understand its contents and conditions.</p> <p>I accept the parental or carer responsibilities contained therein and agree to respect and abide by those codes.</p>			
<b>Parent / carer name:</b>			
<b>Parent email:</b>			
<b>Signature:</b>		<b>Date:</b>	

### Student's agreement to the code of conduct

I, _____, have read and understand the team member code of conduct and agree to abide by its conditions.			
<b>Student Signature:</b>		<b>Date:</b>	

### Any relevant family history



## Student health information – Queensland Representative School Sport

### Privacy Notice

The Department of Education (DoE), through Queensland Representative School Sport is collecting personal information in this form in order to support the health needs of students during representative school sport activities. The forms will be collected by the Team Officials, who will provide them to department staff involved in the running of the event and first aiders/health professionals engaged if the student requires first aid and/or health support during the sporting event.

### Instructions for completing this form

1. Complete Sections 1 to 5 of this form.
2. Attach a copy of any Emergency Health Plans or Action Plans from the student's health practitioner or doctor that support the student's health needs (if required).
3. Contact the Team Official to discuss arrangements if the student has a condition that may require medication as an emergency response and/or if they require additional support to manage their condition.
4. Return the completed form and any attachments to the Team Official by requested date.

### Insurance

The Department of Education does not have personal accident insurance cover for students. If a student is injured as a result of an accident or incident while participating in representative school sport, all costs associated with the injury, including medical costs are the responsibility of the student's parent/carer or adult student themselves.

## Student health information

Section 1: Student Details			
Student name:			
Date of birth:		Year level:	
Parent / carer / contact name:			
Contact phone numbers	Home:	Work:	
	Mob:	Emergency:	
Medical practitioner name:			
Practice name:		Contact number:	



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Section 2: Health conditions		
2.1. Does the student have any health conditions?	<input type="checkbox"/> No Go to 2.3	<input type="checkbox"/> Yes Go to 2.2
2.2 Indicate the student's health conditions/s		
<input type="checkbox"/> Asthma                      Emergency Health Plan / Action Plan attached	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
<input type="checkbox"/> Anaphylaxis                      Emergency Health Plan / Action Plan attached	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
<input type="checkbox"/> Diabetes                              Emergency Health Plan / Action Plan attached	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
<input type="checkbox"/> Epilepsy                              Emergency Health Plan / Action Plan attached	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
<input type="checkbox"/> Other _____		
Attach any Emergency Health Plans or Action Plans relating to the condition and contact the Team Official as soon as possible to discuss any support required to manage the student's health condition, especially if the student requires medication / an emergency response and/or if they require additional support to manage their condition.		
Other emergency Health Plan / Action Plan Attached	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
2.3. Has the student had any recent head injuries or concussion?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Injury details: Describe the injury and treatment.		
Date of injury:		
Management of injury:		
2.4 Does the student have any current or previous sprains, strains, or other injuries (e.g. to the knee, hip, shoulder, ankle or back) which may affect their participation?	<input type="checkbox"/> No Go to 2.6	<input type="checkbox"/> Yes Go to 2.5
2.5 Describe the injury and recent treatment:		
2.6 Is the student medically fit to participate in this sports event? A <b>medical clearance specific to the sport</b> may be required prior to participation in the activity.	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Section 3: Medication requirements		
3.1. Will the student require medication during this activity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.2. Does the student require staff to administer their medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.3. Does the student have parent approval to self-administer their medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If <b>YES</b> to any of these questions:		
<ul style="list-style-type: none"> <li>contact the student's Team Official as soon as possible to ensure that the student's medication needs can be supported and to request the appropriate <i>Consent to administer medication</i> form.</li> </ul>		



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## Section 4: Other

Describe below if the student has any other health related issues which may affect their participation in representative school sport:

## Section 5: Consent

Name of representative sporting event:

Name of student:

Please read the following conditions of participation and indicate your agreement by signing below:

- I have reviewed the information I have provided on this form and confirm that this information is correct.
- To the best of my knowledge, the student named in this form is medically fit and able to participate in this representative sporting event.
- I will notify the Team Official if there is a change in any health conditions detailed above or if the student is no longer medically fit or able to participate fully in the representative school sport activity for which they have been selected, they may be required to withdraw.
- I am aware that the department does not have any personal accident insurance cover for students.
- In the event of an accident or illness, staff may obtain or administer any medical assistance or treatment that the student named in this form may reasonable require.
- I accept liability for all reasonable costs incurred by the department in obtaining such medical assistance or treatment (including transportation costs) and will undertake to reimburse the department the full amount of those costs.

Name of parent or carer:

Signature:

Date:

