

# Springsure District School Sport- Trial Notification

<b>Sport</b>	<b>U10-12yrs Springsure District Cross Country</b>
<b>Date</b>	Wednesday 17th April, 2024
<b>Venue</b>	Springsure Golf Club
<b>Starting Time</b>	9:00 am
<b>Carnival Levy</b>	\$5.00 - to be paid to your school
<b>Finishing Time</b>	11:30pm
<b>Competing Schools</b>	<i>All Springsure District schools can attend</i>
<b>Eligibility</b>	Born in 2012, 2013 or 2014
<b>Regional Carnival</b>	CH Trials- Friday 3 <sup>rd</sup> May 2024 – Springsure Golf Course
<b>Personal/Medical Provisions</b>	Please complete and return medical form and inform trial convenor on day of trials.
<b>Catering</b>	N/A
<b>Trial Convenor</b>	Tiarni Ritchings, Springsure State School <a href="mailto:tritc26@eq.edu.au">tritc26@eq.edu.au</a> or 07 49814333

**Please retain this page for future reference**

## Proposed Cross Country Courses



Marshalling area: At club house.

2KM = Red

3KM = Red plus yellow

### ***PROGRAMME OF EVENTS (approximate times only)***

TIME	AGE GROUP	DISTANCE
<b>9.15 am</b>	<b>Walk the track</b>	
10.00 am	10 Girls	2 Km
10.05 am	10 Boys	2 Km
10.10 am	11 Girls	3 Km
10.15 am	11 Boys	3 Km
10.30 am	12 Girls	3 Km
10.35 am	12 Boys	3 Km

## **ACTIVITY CONSENT and MEDICAL FORM**

### **Activity Risks & Insurance**

Please note that the Department of Education and Training does not have personal accident insurance cover for students. If your child is injured as a result of an accident or incident while participating in the activity, all costs associated with the injury, including medical costs are the responsibility of the parent/carer. Some incidental medical costs may be covered by Medicare. If you have private health insurance, some costs may be also be covered by your provider. Any other costs must be covered by parents/carers. It is up to all parents/carers to decide what types and what level of private insurance they wish to arrange to cover their child. Please take this into consideration in deciding whether or not to allow your child to participate in this activity.

### **Consent**

By signing this form (below) I agree that:

- I have read all of the information contained in this form in relation to the activity (including any attached material) and I am aware that the Department of Education and Training does not have personal accident insurance cover for students.
- I give consent for my child, \_\_\_\_\_ <insert child's name> \_\_\_\_/\_\_\_\_/\_\_\_\_ <DOB>, to participate in **Springsure District Cross Country 10-12yrs on Wednesday, 17<sup>th</sup> April 2024.**
- I will pay to the school the costs detailed above for my child's participation in the activity.
- In the event of an accident or illness, school staff may obtain or administer any medical assistance or treatment my child may reasonably require, including contacting my child's doctor.
- I accept liability for all reasonable costs incurred by the Department of Education and Training in obtaining such medical assistance or treatment (including any transportation costs) and undertake to reimburse the Department of Education and Training the full amount of those costs.
- I have provided the school all relevant details of my child's medical or physical needs on enrolment and where relevant have updated this information.

Parent/Carer Name: \_\_\_\_\_ (Please Print)

Parent/Carer's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **In Case of Emergency on trial day :**

<b>Mother's Name</b>		<b>Work #</b>		<b>Mobile #</b>				
<b>Father's Name</b>		<b>Work #</b>		<b>Mobile #</b>				
If parent/carers unavailable, emergency contact name								
	<b>Work #</b>		<b>Mobile #</b>					
<b>Parent Email:</b>								
<b>Student Medical History</b>	<b>ASTHMA</b>	<b>Y/N</b>	<b>DIABETES</b>	<b>Y/N</b>	<b>ALLERGIES</b>	<b>Y/N</b>	<b>ANAPHYLAXIS</b>	<b>Y/N</b>

### **Additional medical information**

Please give full details of any medical information which may affect your child's full participation in the activity described in the form.

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### **You may also wish to provide the following information\*:**

Name of child's medical practitioner: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Medicare No.: \_\_\_\_\_

Private Health Insurance Company (if applicable): \_\_\_\_\_ Membership No.: \_\_\_\_\_

\*If an enrolment form for your child has been completed or updated since October 2012 this information will already be recorded in OneSchool.

☐ I would like this additional information about my child's medical information to be recorded in OneSchool records.

Receipt details to be completed by School Administration Staff						
School Receipt Reference- RevCode:##### Customer Details: <b>District Cross Country</b>						
<b>Receipt:</b>	<b>Date</b>		<b>Number</b>		<b>Amount</b>	<b>\$</b>

# MEDICATION FORM

**THIS FORM MUST BE RETURNED**

***If this form is not applicable to your child, cross through the table and write 'NOT APPLICABLE'.***

If it is necessary for your child to take medication during the trial period, this form must be completed. The administration of all medication will be made at the direction of the Coach or Manager as outlined in the form below. Under no circumstances, are any personnel to accept responsibility for the giving of drugs to students without prior approval from the Coach or Manager. This includes billeting families.

Date	
Student's name	
Parent's name (in full)	
Parent's telephone number	
Doctor's name	
Doctor's telephone number	
Name of medication	
Dosage of medication	
Time of day medication is to be administered	
Period of time medication is to be administered (maximum of one week)	
Reason for medication	
Parent's/Caregiver's signature	

***Medication container must be clearly labelled by the chemist at the doctor's direction, with your child's name, dosage and instructions for dispensing. This includes paracetamol.***