ACT Education and Training Directorate
Transitions and Careers
51 Fremantle Drive
STIRLING ACT 2614
Ph. (02) 6207 0196
Fax. (02) 6207 2980

PRIMARY SCHOOLS - FLEXIBLE LEARNING OPTIONS (FLO)

EXPRESSION OF INTEREST and PERMISSION NOTE

Name of FLO : **Year 5/6 Transition Program** **Start date: Monday 4 August**

Student Name: ______________________________________ Year: ______________

School: ____

Contact Teacher: ____________________________ Phone Number: ______________

Age: ________ DOB: ________ Shoe Size: __________ Clothing Size: ______________

Brief description as to why the student should be supported in the FLO (teacher to complete):

____

____

Please explain why you would like to complete this FLO (student to complete):

____

____

Please list any learning difficulties you may need assistance with:

____

____

Please list any dietary considerations you may have:

____

____

Please list any allergies or health conditions you may have:

____

____

Please circle:

I have completed the attached Medical Information note Yes No

I am willing to actively participate in the FLO and attend all sessions. Yes No

I give permission for photographs to be taken during the FLO and for these to be used in school newsletters. Yes No

I understand the transport and clothing requirements of the FLO and agree to abide by these. Yes No

I give permission for ____ (*insert student name*)

in Year ____________ at ____ (*insert school*)

to attend the ____ ____flexible learning option.

I agree to my child being under the trainer's authority for the duration of the program and to the trainer being empowered to return my child home at my expense if the trainer considers that the circumstances warrant such action.

I authorise the trainer in charge to make any arrangements, medical or otherwise, necessary for the welfare of my child and agree to meet any costs incurred. I understand that the medical and personal information I have provided on this form will be provided to the trainer.

I understand that it is the responsibility of my child to catch up on any class work they miss during this learning option.

I am aware that the trainer is not responsible for injuries or damage to property which may occur where the trainers have not been negligent. I agree to warn my child of the risk to themselves, others and property through impulsive, willful and disobedient behaviour.

I have read any attached information sheets regarding this learning option and understand what they contain.

Name of Parent/Guardian: ____

Parent/Guardian Signature: ________________________________Date: ______________

Parent Mobile Number: _________________________Home Phone Number: ______________

Please return this form and the medical form to your teacher ASAP. Please scan to FLOs@act.gov.au or fax to 6207 2980 when completed.

The ACT Education and Training Directorate collects this information in order to administer Flexible Learning Options. A student's medical and health information and information about parent and emergency contacts will be provided to the identified trainer who may disclose information to relevant staff and medical officers in the event of an accident or emergency. The information on this form will be stored, used and disclosed in accordance with the requirements of the Privacy Act 1988 (Cwth).

ACT Government

Education and Training

MEDICAL INFORMATION AND CONSENT FORM

The information collected on this form is to assist staff and medical professionals in case of the requirement for first aid and or in the event of an accident or emergency either at school or off site on excursions. Information is personal, is stored on site and a copy of each student's form is taken on any excursion. Information is used in accordance with the regulations of the *Privacy Act 1998(Cwth)*.
Please note: conditions noted with an asterix (*) below require an Emergency Treatment Plan.
In the absence of a plan only standard first aid should be administered.

Personal Details

Student's Name:		Date of Birth:		Sex:	☐ M ☐ F
School:		School Year:		Camp/Excursion:	
Parent/Carer:					
Address:					
Business Hours:		*After Hours:*		*Mobile:*	
Emergency Contacts 1:				Telephone No:	
Emergency Contacts 2:				Telephone No:	
Name of Doctor:				Telephone No:	
Medicare No:		Private Health Fund:		Membership No	
Ambulance Fund: NOTE: Parents are responsible for ambulance costs outside the ACT.					

Please tick if your child suffers any of the following:

☐ allergies
☐ anaphylaxis*
☐ asthma*
☐ other (please specify)
☐ blood pressure
☐ diabetes*
☐ eczema
☐ epilepsy*
☐ fainting
☐ fits or blackouts
☐ hay fever
☐ headaches
☐ heart condition
☐ nose bleeds
☐ reaction to drugs
☐ sight/hearing problems
☐ sun screen sensitivity

***Emergency treatment plan required from your Doctor. Templates are available at or by contacting your school.**
Describe what happens for any of the conditions ticked above

Date of last tetanus injection:	
Is the student presently taking any medication? Parents must give written permission and directions for the administration of any medication taken during school hours or after hours school activities):	Yes ☐ No ☐
Are you aware of any physical or psychological limitations of your child? Please give details.	
Is there any other information which you believe may help us to provide the best possible care?	

Consent to medical attention. In the case of my child requiring medical treatment or in the case of a medical emergency; I consent to the school providing first aid or treatment as outlined in an emergency treatment plan. I authorise the school, where it is impracticable to communicate with me, to arrange for him/her to receive such medical or surgical treatment as may be deemed necessary. I undertake to pay any costs which may be incurred for the medical treatment, ambulance transport and drugs.

Signed.. Date..............................