School for Student Leadership

Trading as ***The Alpine School***
PO Box 53
Great Alpine Road
Dinner Plain, VIC 3898

CONFIDENTIAL STUDENT INFORMATION

Student Details

First Name:_____ **Middle:**_____ **Surname:**_____

Home School:_____

Residential Address:_____ **Postcode:**_____

Date of Birth:_____ **Gender:**_____ **Vic Department Student Number:**_____

I am attending the _____ **campus of the School for Student Leadership in Term**_____

Guardian Details

Guardian #1:_____ **Guardian #2:**_____

Relationship to Student:_____ **Relationship to Student:**_____

Mobile Phone:_____ **Mobile Phone:**_____

Home Phone:_____ **Home Phone:**_____

Work Phone:_____ **Work Phone:**_____

Primary Email:_____ **Secondary Email:**_____

Alternative Emergency Contact: Non-Guardian

Name:_____ **Relationship to Student:**_____

Preferred Phone:_____ **Work Phone:**_____

Living Details

Are there restraining/custodial orders? ◯ **Yes** ◯ **No** **Details:**_____

Are you an Australian Citizen? ◯ **Yes** ◯ **No** **Details:**_____

Do you identify as Aboriginal Australian? ◯ **Yes** ◯ **No** **Details:**_____

Do you have any Religious Observances? ◯ **Yes** ◯ **No** **Details:**_____

Medical Insurance Details

Do you have ambulance cover? ◯ **Yes** ◯ **No** **Card #:**_____

Do you have health care or pension card? ◯ **Yes** ◯ **No** **Details:**_____

Do you have private health insurance? ◯ **Yes** ◯ **No** **Details:**_____

Medicare #:_____ [Ref#] **Medicare Expiry:**_____

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PERSONAL COMMITMENTS

The School for Student Leadership (SSL) is a residential school for Victorian government students, which provides opportunities for personal, community and leadership development. As part of this unique residential experience, there are a number of commitments required from families involved in the program. ***The full details of each commitment are in the SSL School and Program Information Handbook, and should be read and discussed by both a guardian and the student before agreeing below.***

Student Name:_____ **School:**_____

General Consent

We have read and understand the *"SSL General Consent Agreement."* We accept the risks involved with the SSL program. We consent to provide honest and relevant information as requested by the SSL. We understand the appropriate expectations for SSL participants. We accept the implications should participants not comply. ◯ **Yes** ◯ **No**

Bullying Policy

We have read and understand the *"SSL Bullying Policy."* We accept the SSL approach to managing bullying and the values underpinning this approach. We accept the implications should participants not comply. ◯ **Yes** ◯ **No**

Laptop Policy

We have read and understand the "*SSL Laptop Policy."* We know the appropriate and inappropriate files, programs or websites accepted or condoned during the SSL program. We accept our responsibility as custodian of a laptop. We accept the implications should participants not comply. ◯ **Yes** ◯ **No**

Recording Authorisation

We have read and understand the *"SSL Recording Authorisation."* We understand that images and video of students participating in the program will be published online, but will not include student names. ◯ **Yes** ◯ **No**

M-Rated Films Authorisation

We have read and understand the *"M-Rated Films Authorisation."* We understand the M-Rated Film list and their educational benefit. We understand that all M-Rated films shown will be supervised by adults. ◯ **Yes** ◯ **No**

Medical Treatment Authorisation

We have read and understand the *"Consent to Medical Treatment Agreement."* We authorise SSL Staff to provide appropriate over-the-counter medication or arrange appropriate medical treatment as deemed necessary. We acknowledge that SSL Staff will act as legal guardian in all matters requiring attention from medical professionals. ◯ **Yes** ◯ **No**

Personal Agreements

We agree to the terms and conditions of the SSL Leadership Program commitments listed above. Please Sign.

Guardian:_____ **Student:**_____

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MEDICAL CONDITIONS SUMMARY

Please provide all relevant information to the best of your ability. The SSL program is developed to be inclusive of all participants, regardless of physical, emotional or mental capacity. The SSL team can modify all curriculum and activities as appropriate to ensure every participant has a safe and fulfilling experience.

Student Name:_____ **School:**_____

Physical Conditions

Do you have any of the following impairments? ◯ **Hearing** ◯ **Vision** ◯ **Speech** ◯ **Mobility**

Details:_____

Do you have? ◯ **Disturbed Sleeping** ◯ **Limited Swimming Ability** ◯ **Physical Injuries** ◯ **Dietary Needs**

Details:_____

Medical Conditions

Do you have? ◯ **Asthma** ◯ **Allergies** ◯ **Diabetes** ◯ **Epilepsy** ◯ **Mental Health Concern** **If so, fill out appropriate form*

Do you have any other medical conditions? ◯ **Yes** ◯ **No** **Details:**_____

Learning Difficulties

Do you have any learning difficulties? (eg- Dyslexia, ADHD, Autism) ◯ **Yes** ◯ **No**

Details on how the SSL can best support your child:_____

Tetanus Immunisation

Have you had tetanus immunisation? ◯ **Yes** ◯ **No** **Year of last immunisation:**_____

*** Tetanus immunisation is normally given at five years of age and at fifteen years of age.**

Medications

Medication Name	Condition	Dosage	Timing	Regime	Comments
			◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	
			◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	
			◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	
			◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	

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ASTHMA MANAGEMENT FORM

Student Name:_____ **School:**_____

History

Have you been admitted to hospital due to asthma in the last 12 months? ◯ **Yes** ◯ **No**
Have you been on oral cortisone for asthma in the last 12 months? ◯ **Yes** ◯ **No**
Have you ever suffered sudden severe asthma attacks requiring hospitalisation? ◯ **Yes** ◯ **No**

** If you have answered "yes" to any of the above questions then the decision for the person to participate rests with the child's doctor. The doctor or guardian may contact the school Principal for further information on the program. A letter from the student's doctor, stating the doctor's decision must accompany this form.*

Date of last asthma attack:_____ **Severity of last attack:**_____

What are your peak flow readings? **Best:**_____ **Critical:**_____

Does your child need help taking their asthma medication? ◯ **Yes** ◯ **No**

Triggers, Signs & Symptoms

Causes of Asthma: ◯ **Colds/Flu** ◯ **Exercise** ◯ **Pollens** ◯ **Dust** ◯ **Cold Weather** ◯ **Animal Hair**
◯ **Other:**_____

Typical Asthma Signs: ◯ **Wheezing** ◯ **Coughing** ◯ **Chest Tightness** ◯ **Difficulty Speaking** ◯ **Difficulty Breathing**
◯ **Other:**_____

Critical Asthma Signs: ◯ **Wheezing** ◯ **Coughing** ◯ **Chest Tightness** ◯ **Difficulty Speaking** ◯ **Unknown**
◯ **Other:**_____

Asthma Medications

Medication Name	Dosage	Method	Regime	Timing	Comments
		◯ Puffer ◯ Spacer ◯ Turbo haler ◯ Other	◯ Daily ◯ As Reqd. ◯ In Crisis	◯ AM ◯ PM ◯ Noon	
		◯ Puffer ◯ Spacer ◯ Turbo haler ◯ Other	◯ Daily ◯ As Reqd. ◯ In Crisis	◯ AM ◯ PM ◯ Noon	
		◯ Puffer ◯ Spacer ◯ Turbo haler ◯ Other	◯ Daily ◯ As Reqd. ◯ In Crisis	◯ AM ◯ PM ◯ Noon	

SSL Policy for Emergency Treatment of Asthma

1. Sit the student down and reassure the student. Without delay give 4 puffs of a Reliever Inhaler (Ventolin, Respolin or Bricanyl), using a spacer. Spacer technique = 1 puff, then take 4 breaths from spacer, repeat until 4 puffs have been given.

2. Wait 4 minutes. If there is no improvement, give another 4 puffs, as per step two.

3. If there is no improvement, call an ambulance (000) immediately and state that "a student is having an asthma attack".

4. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.

Emergency Treatment

In emergencies, would you like staff to follow the SSL Policy for Emergency Treatment of Asthma? ◯ **Yes** ◯ **No**

** If "no", please attach your preferred medication and treatment to be used during crisis situations.*

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ALLERGY MANAGEMENT FORM

Student Name:_____ **School:**_____

Triggers

Causes of Allergic Reactions:_____

_____

History

Have you ever suffered sudden severe allergic attacks requiring hospitalisation (anaphylaxis)? ◯ **Yes** ◯ **No**

Have you been admitted to hospital due to an allergic reaction the last 12 months? ◯ **Yes** ◯ **No**

** If you answered "yes" to either of the above questions, please describe:*

Date of attack:_____ **Severity of attack:**_____

Describe how the SSL should support your child in managing allergies:_____

_____

_____

Signs & Symptoms

** Please select the signs and symptoms of a typical allergic reaction for the student:*

Mild Signs:
◯ **Localised Swelling** ◯ **Localised Rash/Itch** ◯ **Tingling Mouth** ◯ **Vomiting**
◯ **Abdominal Pain** ◯ **Runny Eyes/Nose** ◯ **Sneeze/Cough** ◯ **Hives**

Severe Signs:
◯ **Difficulty Breathing** ◯ **Swollen Tongue** ◯ **Tightness in throat** ◯ **Unknown**
◯ **Difficulty Talking** ◯ **Collapse** ◯ **Loss of consciousness**

◯ **Other:**_____

Allergy Medications

Medication Name	Dosage	Timing	Regime	Comments
		◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	
		◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	

SSL Policy for Emergency Treatment of Anaphylaxis

Mild Reaction: Stay with person and seek help. Provide prescribed medications. If none prescribed, provide a relevant combination of; over the counter antihistamines, over the counter pain relief, cold compress, first aid creams and rest.

Severe Reaction: Provide prescribed medications. If no improvement, call ambulance & give EpiPen. Lay person flat and elevate legs. If breathing is difficult, allow to sit but do not stand. Further EpiPen doses may be given if no response after 5 minutes.

Emergency Treatment

In emergencies, would you like staff to follow the SSL Policy for Emergency Treatment of Anaphylaxis? ◯ **Yes** ◯ **No**

** If "no", please attach your preferred treatment to be used during crisis situations.*

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DIABETES MANAGEMENT FORM

Student Name:_____ **School:**_____

History

Is this student usually able to self-manage their own diabetes care? ◯ Yes ◯ No

Does this student regularly test and record their blood sugar levels (BSL)? ◯ Yes ◯ No

Describe how the SSL should support your child in managing diabetes:_____

_____

_____

_____

Signs & Symptoms- Hypoglycaemia

** Please select the signs and symptoms of a typical Hypoglycaemia (low blood sugar):*

Mild: ◯ Sweating ◯ Paleness ◯ Trembling ◯ Unclear thinking ◯ Hunger ◯ Weakness ◯ Mood Change ◯ Lack of coordination

Moderate: ◯ Headache ◯ Glazed Expression ◯ Abdominal Pain ◯ Seemingly Intoxicated ◯ Nausea ◯ Disorientation ◯ Inability to drink without encouragement

Severe: ◯ Unconscious ◯ Inability to stand ◯ Cannot respond to instructions ◯ Seizures ◯ Extreme Disorientation ◯ Unknown

Signs & Symptoms- Hyperglycaemia

** Please select the signs and symptoms of a typical Hyperglycaemia (high blood sugar):*

Mild: ◯ Frequent Urination ◯ Lethargy ◯ Weight Loss ◯ Change in behaviour ◯ Excessive Thirst

Severe: ◯ Rapid Breathing ◯ Vomiting ◯ Red Face ◯ Abdominal Pain ◯ Sweet Breath ◯ Severe Dehydration ◯ Unconscious ◯ Unknown

Diabetes Medications

Medication Name	Dosage	Timing	Regime	Comments
		◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	
		◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	

SSL Policy for Emergency Treatment of Diabetes

Hypoglycaemia: Give glucose immediately. Wait for 5 minutes. If no improvement, repeat giving of glucose. If improvement, follow up with bread or biscuits when recovered. If no still no improvement, call 000. Monitor airway & breathing.

Hyperglycaemia: Provide prescribed medications (insulin). Encourage drinking of water. Lay person flat and elevate legs. If breathing is difficult, allow to sit but do not stand. If no still no improvement, call 000. Monitor airway & breathing.

Emergency Treatment

In emergencies, would you like staff to follow the SSL Policy for Emergency Treatment of Diabetes? ◯ Yes ◯ No

** If "no", please attach your preferred treatment to be used during crisis situations.*

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EPILEPSY MANAGEMENT FORM

Student Name:_____ **School:**_____

History

Known triggers for seizures:_____

Do you get partial (focal)seizures? ◯ Yes ◯ No **Side of the brain affected :**_____

Do you get generalised seizures? ◯ Yes ◯ No **Type:** ◯ Tonic/Clonic ◯ Absence ◯ Myoclonic

Typical warning signs prior to seizure:_____

Typical length of seizures_____ **Typical recovery time:**_____

Describe how the SSL should support your child in managing epilepsy:_____

_____

_____

Signs & Symptoms

** Please select the signs and symptoms of a typical epileptic event:*

Simple Partial:
◯ Staring ◯ Rapid Blinking ◯ Inability to talk ◯ Jerking of body parts
◯ Headache ◯ Altered Sensations ◯ Digestive Malfunction

Complex Partial:
◯ Staring & Unaware ◯ Eyes jerking uncontrollably ◯ Chewing Movement
◯ Disorientation ◯ Fiddling with clothes/objects

Generalised:
◯ Non responsive ◯ Discoloured Face ◯ Sudden falling ◯ Sudden outcry
◯ Incontinence ◯ Body becomes stiff ◯ Jerking of arms/legs ◯ Biting
◯ Brief vacant stare ◯ Sudden, simple jerk ◯ Excess Saliva ◯ Loss of awareness

◯ **Other:**_____

Epilepsy Medications

Medication Name	Dosage	Timing	Regime	Comments
		◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	
		◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	

SSL Policy for Management of Epilepsy

Minor Seizures: Stay calm. Remove harmful objects. Stay with the person & time the seizure. Rest & reassure.

Major Seizures: Stay calm. Remove harmful objects, loosen tight clothing and place padding under their head. Stay with the person & time the seizure. When over, roll the person onto their side and keep airway clear. Treat any injuries. Rest & reassure.

Ambulance will be called if: Seizures are longer than 5-10 minutes. Another seizure follows quickly. Person remains unconscious. Person is severely injured. You are about to administer diazepam or midazolam. You are unsure.

Emergency Treatment

In emergencies, would you like staff to follow the SSL Policy for Management of Epilepsy? ◯ **Yes** ◯ **No**

** If "no", please attach your preferred treatment to be used during crisis situations.*

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MENTAL HEALTH MANAGEMENT FORM

The School for Student Leadership is committed to creating an inclusive learning environment that supports the mental health and wellbeing of all students. This form allows SSL staff, in collaboration with families and home schools, to determine support options for students with a suspected or confirmed mental health difficulty. Referral to a clinical care provider if deemed necessary (eg- Psychologist or Youth Mental Health) will always be discussed with families prior to arrangements being made.

Student Name:_____ **School:**_____

Access to Services

Have you ever spoken with a mental health service provider? (eg- Chaplain, Psychologist, Counsellor) ◯ **Yes** ◯ **No**

Details of relevant history:_____

Mental Health Conditions

Do you have any current mental health concerns? (eg- anxiety, depression, self-harm, disordered eating) ◯ **Yes** ◯ **No**

Details on how the SSL can best support you:_____

Current Support Agencies

Agency	Contact Person	Contact details (phone/email)

Mental Health Support Plan

Issue	Goal	Strategy/Comments

Medications

Medication Name	Dosage	Timing	Regime	Comments
		◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	
		◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	
		◯ AM ◯ PM ◯ Noon	◯ Daily ◯ As Reqd.	

** If applicable, please attach additional details to the back of this form **