alta-1 COLLEGE

Queensland Enrolment Application Pack

CHANGING LIVES ONE AT A TIME

APPLICATION CHECKLIST

Application Forms

- ☐ Every page of the Application pack completed, and signed by both parent/guardian and student where required, including:
  - ☐ Direct Debit form – for school fees (No fees will be taken out until the student begins at Alta-1)
  - ☐ Medication at School form – in case the student requests Panadol/Nurofen at school
  - ☐ Asthma/Anaphylaxis/Allergies forms - if relevant
  - ☐ Doctor's details (p.8)
  - ☐ Medication details (p.8, p.20)

Required Documents

- ☐ Birth Certificate/ AUS Passport (or NZ Passport/ Citizenship/Residency document)
- ☐ Medicare Card
- ☐ Immunisation History Statement
  (*Must be less than 3 months old. Available online from MyGov or Medicare; in person at Centrelink office; by phone 1800 653 809)*
- ☐ 2 x previous School Reports
- ☐ Student Profile, Behaviour/Safety plans, EAP, IEP, SET Plans, ISP, other documented plans from previous school
- ☐ Medical/psychological reports and/or diagnoses, care plans, referral letters etc.
- ☐ For independent students - Centrelink allowance statement/letter
- ☐ Alta-1 Referral Form to be completed by a suitable referee as stated on the form
- ☐ Court Orders/ Child Protection Orders (where relevant)

STANDARD COLLECTION NOTICE

1. The College collects personal information, including sensitive information about students and parents or guardians before and during the course of a student's enrolment at the College. This may be in writing or in the course of conversations. The primary purpose of collecting this information is to enable the College to provide schooling to students enrolled at the college, exercise its duty of care, engage in marketing/fundraising and perform necessary associated administrative activities, which will enable students to take part in all the activities of the College.
2. Some of the information we collect is to satisfy the College's legal obligations, particularly to enable the College to discharge its duty of care.
3. Laws governing or relating to the operation of a school require certain information to be collected and disclosed. These include relevant Education Acts, and Public Health and Child Protection laws.
4. Health information about students is sensitive information within the terms of the Australian Privacy Principles (**APPs**) under the *Privacy Act 1988*. We may ask you to provide medical reports about students from time to time.
5. The College may disclose personal and sensitive information for educational, legal, administrative, marketing and support purposes. This may include to:
   - other schools and teachers at those schools;
   - government departments (including for policy and funding purposes);
   - medical practitioners;
   - people providing educational, support and health services to the College, including specialist visiting teachers, [sports] coaches, volunteers, and counsellors;
   - providers of learning and assessment tools;
   - assessment and educational authorities, including the Australian Curriculum, Assessment and Reporting Authority (ACARA), Queensland Curriculum and Assessment Authority (QCAA), and NAPLAN Test Administration Authorities (who will disclose it to the entity that manages the online platform for NAPLAN);
   - people providing administrative and financial services to the College;
   - anyone you authorise the College to disclose information to; and
   - anyone to whom the College is required or authorised by law, including child protection laws, to disclose the information.
6. Personal information collected from students is regularly disclosed to their parents or guardians.
7. The College may use online or 'cloud' service providers to store personal information and to provide services to the College that involve the use of personal information, such as services relating to email, instant messaging and education and assessment applications. Some limited personal information may also be provided to these service providers to enable them to authenticate users that access their services. This personal information may reside on a cloud service provider's servers which may be situated outside Australia. Further information about the College's use of on online or 'cloud' service providers is contained in the College's Privacy Policy.
8. The College's Privacy Policy, accessible on the College's website, sets out how parents or students may seek access to and correction of their personal information which the College has collected and holds. However, access may be refused in certain circumstances such as where access would have an unreasonable impact on the privacy of others, where access may result in a breach of the College's duty of care to a student, or where students have provided information in confidence. Any refusal will be notified in writing with reasons if appropriate.
9. The College's Privacy Policy also sets out how parents and students can make a complaint about a breach of the APPs and how the complaint will be handled.
10. The College may engage in fundraising activities. Information received from you may be used to make an appeal to you. [It may also be disclosed to organisations that assist in the College's fundraising activities solely for that purpose.] We will not disclose your personal information to third parties for their own marketing purposes without your consent.
11. On occasions information such as academic and sporting achievements, student activities and similar news is published in College newsletters and magazines, on our intranet and website. This may include photographs and videos of student activities such as sporting events, college camps and college excursions. The College will obtain permissions during enrolment from the student's parent/guardian (and from the student if appropriate) if we would like to include such photographs or videos [or other identifying material] in our promotional material or otherwise make this material available to the public such as on the internet.
12. We may include students' and students' parents' contact details in a class list and College directory.
13. If you provide the College with the personal information of others, such as doctors or emergency contacts, we encourage you to inform them that you are disclosing that information to the College and why.

Parent/Guardian Signature: _____ Student Signature: _____

Alta-1 College (QLD) Ltd | ABN: 30 160 751 253

Suites 12 & 14, 42-44 King Street
Caboolture QLD
PO Box 388, Caboolture, QLD 4510
t. +61 (7) 5301 8008 f.+61 (8) 9403 8299
e. admin@alta-1.qld.edu.au
Website: www.alta-1.com.au

Application for Enrolment

STUDENT DETAILS

Surname: _____ USI Number: Yes ☐ _____ No ☐

Given Name/s: _____ Preferred Name: _____

Gender (as per Birth Certificate): M ☐ F ☐ Date of Birth: _____

Country of Birth: _____ Nationality: _____
(Please provide copy of Birth Certificate. Please also provide copy of Visa if born outside of Australia)

Main Language spoken: _____ Main Language spoken at home: _____

1. Aboriginal but not Torres Strait Islander descent ☐
2. Torres Strait Islander but not Aboriginal descent ☐
3. Both Aboriginal and Torres Strait Islander descent ☐
4. Neither Aboriginal nor Torres Strait Islander descent ☐

Immunisation history available? Yes ☐ No ☐ *(Please provide a copy of Immunisations)*

Present or Previous School: _____

Year level previously completed and when: _____
(Please provide a copy of two previous school reports)

Home address (while enrolled in the program): _____

_____

Student Phone Number: _____ Student Email: _____

PHOTO AUTHORISATION

Authorisation is needed to use students' photographs in different publications. In the event a photo of your child is published, only the first name will be used to ensure confidentiality.

Please place a tick in the boxes below indicating what areas you are happy to have your child's photograph/s used in, including videos and power point presentations. Newsletters will not only be issued to students, but also placed on the website.

Website ☐ Promotional Material ☐ School Publications ☐

CONTACT DETAILS OF RESPONSIBLE PARENT/GUARDIAN

Title: _____ Full Name: _____

Relationship to the Student: _____

Home Address: _____

Postal Address: ('As Above' if the same) _____

Contact Number: _____ Work Number: _____

Email: _____

FAMILY DETAILS

Mother

Title: _____

Full Name: _____

Home Address: _____

_____ P/Code : _____

Occupation: _____

Contact number: _____

1. Aboriginal but not Torres Strait Islander descent ☐
2. Torres Strait Islander but not Aboriginal descent ☐
3. Both Aboriginal and Torres Strait Islander descent ☐
4. Neither Aboriginal nor Torres Strait Islander descent ☐

Father

Title: _____

Full Name: _____

Home Address: _____

_____ P/Code: _____

Occupation: _____

Contact number: _____

1. Aboriginal but not Torres Strait Islander descent ☐
2. Torres Strait Islander but not Aboriginal descent ☐
3. Both Aboriginal and Torres Strait Islander descent ☐
4. Neither Aboriginal nor Torres Strait Islander descent ☐

Marital Status:

Married/De facto ☐ Separated ☐ Single ☐ Divorced ☐ Widowed ☐

CUSTODY/GUARDIANSHIP DETAILS

Student resides: Permanently with: _____ Occasionally with: _____

Custody Details/Access Restrictions? YES ☐ NO ☐

(Please include a copy of any Court Orders)

_____

_____

Alternative Family Information:

_____

_____

If you wish for another person to contact the school regarding your child, please advise below. YES ☐ NO ☐

Name and contact number of alternative person/s: _____

_____

EMERGENCY CONTACT (3)	**EMERGENCY CONTACT (4)**
Other than Parent/Guardian who will be contacted first	Other than Parent/Guardian who will be contacted first
Name _____	Name _____
Phone (Hm) _____	Phone (Hm) _____
Mobile _____	Mobile _____
Relationship to student: _____	Relationship to student: _____

The following information is required by the Australian Government to determine the level of funding the College is allocated

Parent/Guardian 1: _____

Country of Birth: _____ Main Language spoken at home: _____

What is the highest year of primary or secondary school completed? (Please tick the appropriate box)

☐ 1. Year 9 or equivalent or below
☐ 2. Year 10 or equivalent
☐ 3. Year 11 or equivalent
☐ 4. Year 12 or equivalent

What is the level of the highest qualification completed? (Please tick the appropriate box)

☐ 5. Certificate I to IV (incl. trade certificate)
☐ 6. Advanced Diploma/Diploma
☐ 7. Bachelor degree or above
☐ 8. No non-school qualification

Occupation group (Please tick the appropriate box)

☐ 1. Senior management and qualified professionals
☐ 2. Other business managers, arts/media/sport, associated professionals
☐ 3. Tradesmen/women, clerks, skilled office, sales, service
☐ 4. Machine operators, hospitality, assistants, labourer, etc.
☐ 8. Not in paid work in last 12 months
☐ 9. Not stated or unknown

Parent/Guardian 2: _____

Country of Birth: _____ Main Language spoken at home: _____

What is the highest year of primary or secondary school completed? (Please tick the appropriate box)

☐ 1. Year 9 or equivalent or below
☐ 2. Year 10 or equivalent
☐ 3. Year 11 or equivalent
☐ 4. Year 12 or equivalent

What is the level of the highest qualification completed? (Please tick the appropriate box)

☐ 5. Certificate I to IV (incl. trade certificate)
☐ 6. Advanced Diploma/Diploma
☐ 7. Bachelor degree or above
☐ 8. No non-school qualification

Occupation group (Please tick the appropriate box)

☐ 1. Senior management and qualified professionals
☐ 2. Other business managers, arts/media/sport, associated professionals
☐ 3. Tradesmen/women, clerks, skilled office, sales, service
☐ 4. Machine operators, hospitality, assistants, labourer, etc.
☐ 8. Not in paid work in last 12 months
☐ 9. Not stated or unknown

STUDENT MEDICAL INFORMATION

Student's Full Name: _____

Has the student ever been diagnosed with any of the following? *(Tick if applicable)*
Please note that the answers to these questions won't determine whether the student is accepted into Alta-1, however it will help to give staff a better understanding and equip us to care for the student appropriately.

☐ Autism Spectrum Disorder (ASD)

Details:

☐ Deaf and Hard of Hearing

Details:

☐ Vision Impairment

☐ Dyslexia (physiological, needing correction by coloured lens or overlays)
☐ Other: _____

☐ Intellectual Disability

IQ score below 69 and deficits in adaptive behaviour, such as self-care, independence, safety, etc.
Details:

☐ Physical Disability

Details:

☐ Medical/Health Condition

☐ Diabetes
☐ Arthritis
☐ Chronic Fatigue
☐ Fibromyalgia
☐ Chronic Pain
☐ Asthma
☐ Allergies
☐ Anaphylaxis (Beestings/food)
☐ Epilepsy
☐ Heart Disorder
☐ Other: _____

***Please attach Management Plan/s**

☐ Speech and Language Impairment

☐ Dyslexia (Spelling, Comprehension and Reading Difficulty)
☐ Dysgraphia (Writing)
☐ Dyscalculia (Mathematics and numeracy)
☐ Dyspraxia (Verbal and/or motor co-ordination)
☐ Language or speech disorder (E.g. stutter)
☐ Other: _____

☐ Mental/Behavioural Disorder

☐ Depression
☐ Anxiety
☐ Drug/alcohol issues/addiction
☐ Anorexia
☐ Bulimia
☐ Bipolar Disorder (previously known as manic depression)
☐ Motor Disorders such as tics, Tourette's etc.
☐ Attention Deficit Hyperactivity Disorder (ADHD)
☐ Other: _____
☐ Trauma and post-traumatic stress (PTSD)
☐ Schizophrenia or other psychotic disorders
☐ Obsessive Compulsive Disorder (OCD)
☐ Oppositional Defiant or Conduct Disorder

Other
Please provide information relating to any diagnosis not listed above or any **Health Issue** that may impact your child's performance (i.e. Significant illness or conditions / previous surgery / head or brain injury).
Risk to harm self: ☐ Low ☐ Medium ☐ High
Details: (i.e. S
Risk to harm others: ☐ Low ☐ Medium ☐ High
Details:
Substance use (e.g. Drugs, Alcohol)
Details:

Doctor's Name / Medical Centre: _____

Address: _____

Phone No: _____

Support agencies accessed by your child (e.g. Headspace):

_____

_____

Please list any medications administered at home and any emergency medications.
(*This is for reference purposes and may be useful information for health professionals in case of an emergency.)*

Name of Medication	Strength (eg 10mg)	Dosage (eg 1 tablet)	How to be given	Times to be given at school	Other useful instructions or information

Medicare No: _____ Individual Number: _____ Valid To: _____

REQUEST TO ADMINISTER MEDICATION AT SCHOOL FORM

(Valid for 12 months, new form to be completed at the beginning of each year)

This form must be completed for all students requiring medication (prescription and non-prescription) during school hours with the exception of antibiotics and short-term medication. This must include written instructions from the parent/guardian and delivered to the campus teacher. Note however: Alta-1 College staff will never take responsibility for the administration of any medication by injection.

Student Name: _____ Date of Birth: _____ Year Level: _____

Student Allergies: _____

Please list medications that your child may require during school hours

Name of Medication	Strength (eg 10mg)	Dosage (eg 1 tablet)	How to be given	Times to be given at school	Other useful instructions or information

I give permission for my child to be administered the following pain and allergy relief medication(s) if required:

☐ Paracetamol ☐ Ibuprofen ☐ Antihistamine

Further Information:

- Alta-1 College staff will never take responsibility for the administration of any medication by injection.
- For College staff to administer any medication (including over the counter medication), a medical certificate or letter is required from a medical practitioner.
- The College is not permitted to administer "natural" remedies from alternative therapy practitioners.

The following points are for security and safety purposes and are a requirement of the Health (Drug and Poisons) Regulation 1996 (QLD).

Parents/guardians must:

- Notify the school in writing to administer medication. This may include written guidelines from the prescribing medical practitioner, including potential side effects or adverse reactions.
- Provide medication in the original pharmacy labelled container to the school
- Provide the medication with the original pharmacy label detailing the student's name, dosage and times to be taken
- Not provide out of date medication
- Notify the school in writing when a change of dosage is required. This instruction is to be accompanied by a letter from a prescribing health practitioner or change of label from a pharmacist.
- Notify the school if the student has received a dose at home with ill effects
- Advise the school in writing and collect from the school when the medication is no longer required at school

Parent Declaration:

☐ I hereby request that school staff administer the above necessary medication to my child while at school.

☐ I agree to notify the school in writing, if there are any changes in the above medication.

Parent/Guardian Name: _____ Signature: _____ Date: _____

EXCURSION MEDICAL FORM

The information in this form is collected so that teachers and staff members have critical medical information for students on hand during excursions.

Student Name: _____

1. Medical Conditions:

If your child suffers from any current or chronic illness, please indicate here:

☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Allergies ☐ Anaphylaxis ☐ Other: _____

If you indicated any condition above, you **must** supply a detailed illness management plan as a separate attachment to this form **and** indicate in this box: ☐ Management plan attached.

2. Medications:

(a) General – I give permission for my child to be administered the following pain and allergy relief medication(s) if required: ☐ Paracetamol ☐ Ibuprofen ☐ Antihistamine

(b) Particular – Please indicate whether your child is taking any form of regular medication:

☐ My child is **not** taking any regular form of medication

☐ My child **is** taking the following regular medication: _____

and I have attached a separate detailed medication management plan.

Note: It is not the responsibility of any Alta-1 staff to administer any medication by injection.

3. Emergencies:

I give permission for Alta-1 staff to seek medical attention for my child should it be necessary, and release to you the following details:

- Medicare number: _____ Line number: _____ Expiry date: _____
- Emergency day contact – Name: _____ Phone: _____
- Emergency night contact – Name: _____ Phone: _____

Parent/guardian name: _____

Parent/guardian signature: _____ Date: _____

STUDENT TRANSPORT ARRANGEMENTS

It is important that the College is fully aware of transport arrangements for students to and from school so that it can properly dispose its duty of care to students. Please tick the box that reflects the arrangement that you have in place for getting your child to and from school. Please provide further information if none of the options below are applicable.

- ☐ I drop my child off each morning and pick my child up each afternoon
- ☐ My child requires a pick up and drop off at the Caboolture Train Station each day
- ☐ My child makes their own way to and from school each day
- ☐ There is an alternative arrangement in place for my child *(please provide details)*

Details:

_____

_____

_____

_____

EDUCATION ADJUSTMENT PROGRAM (EAP)

Dear Parent/Guardian,

To meet the individual needs of students at the College, including those with a disability, Alta-1 provides adjustments in order to address the student's identified learning needs and build on their strengths.

The Education Adjustment Program (EAP) is the process used in Queensland to determine eligibility to access state funding assistance to support students requiring adjustments due to a disability in an identified category. Alta-1 submits verification documentation to Independent Schools Queensland (which includes diagnosis and/or doctor's letters etc.) to determine eligibility for funding support.

Which students are eligible?
Students who are eligible for EAP support include those with:

- Hearing Impairment
- Physical Impairment
- Vision Impairment
- Autism Spectrum Disorder
- Intellectual Disability
- Speech-Language Impairment
- Social Emotional Disorder (Psychiatric Disorder)

What is the benefit for your child?
If your child has been verified through an EAP then Alta-1 receives additional state government funding in order to cater for their needs. This funding is received by the school and provides for additional resourcing. This extra resourcing means that student needs can be better met.

My child doesn't have an impairment or disability.
That's great. This program is only for those who have a formal diagnosis and is not applicable to all students. Sometimes the school staff will request that you undertake further investigation for your child under one of the impairment or disability areas. Some of the young people enrolled in Alta-1 College may be eligible for funding under the Social Emotional Disorder category.

What do I need to do?
Please read the following two pages. These pages are a form that Independent Schools Queensland requires in order to allocate additional funding for any student with a disability. Whether or not your child has a disability we ask that you consider signing the form in the case that Alta-1 does need to apply for an EAP for you child. Don't hesitate to contact the College should you have any questions.

Yours sincerely,

Matthew Vandepeer
Principal

EAP Consent Form 2

This form is used to record consent for the school to collect information to assist in determining the student's eligibility for and participation in the Education Adjustment Program (EAP).

EAP is a Department of Education (DoE) process for identifying and responding to the educational needs of students with disability. Adjustments are made for students with disability to enable them to access the curriculum, achieve curriculum outcomes and participate in school life.

The EAP process initiates an ongoing cycle of documented data collection, planning, program development, intervention, evaluation and review.

Privacy Statement

Independent Schools Queensland (ISQ) collects, uses and discloses student's personal information in accordance with the confidentiality provision in s.426 of the Education (General Provisions) Act 2006 and the Australian Privacy Principles Schedule1 Privacy Amendment (Enhancing Privacy Protection) Act 2012. Information on the student's medical, developmental and educational status and history is being collected, used or disclosed for the purpose of the Education Adjustment Program. The information will be kept in a secure location and will only be accessed by relevant Independent Schools Queensland personnel. Student's information will not be given to any other person or external body unless consent has been provided or Independent Schools Queensland is permitted or required by law to use or disclose such information. Information given to the professionals or agencies listed below is for the purpose of informing their professional service to the student.

Student Details

Last Name		Date of Birth	
First Name		Gender	
School	Alta-1 College QLD	Year Level	
Parent		Home Phone	
General Practitioner			
Contact Details			
Medical Specialist			
Contact Details			

OTHER AGENCIES OR PROFESSIONALS (Supporting the student)

	Agency / Professional	Contact Person	Contact Details
x			
x			
x			
x			
x			
x			
x			

Adapted with Permission from Department of Education (DoE) - Queensland Government

The school team should ensure that the parents and student (as applicable) are supported to understand the EAP process.

Consent

I give consent for:

- Independent Schools Queensland (ISQ) to collect personal information for the purpose of the Education Adjustment Program
- the school to share relevant personal information with advisory/specialist teachers and therapists for the purpose of the Education Adjustment Program
- the school to share relevant personal information with the student's general practitioner and medical specialist (as listed above) for the purpose of the Education Adjustment Program
- the school to share relevant personal information with agencies or professionals listed above for the purpose of the Education Adjustment Program
- the agencies or professionals listed to report to the school with diagnostic information and information to support educational planning
- participation in the EAP review processes (verification, review and validation) according to review date/s specified or at my request
- the school to disclose information recorded on EAP Verification Form/s and relevant attachments and the completed EAP to the Department of Education (DoE) and the data to be recorded on the DoE record management system
- DoE to provide to ISQ and/or the school, data recorded on the DoE record management system containing summary details of my child's demographics, enrolment history and disability verification when requested by relevant ISQ officers. This is to assist ISQ in identifying, coordinating and confirming the support provided by DoE Advisory Visiting Teachers (AVT).

Parent Name			
Parent Signature	sign here	Date	
Student Name			
Student Signature	sign here	Date	
School Representative Name	Matthew Vandepeer	Position	Principal
School Representative Signature	sign here	Date	

If the principal decides that the student is capable of giving their own informed consent, students are also required to sign this consent form, preferably in addition to the parent/carer signature.

Note:

1. **The original of this form is to be kept in the student's school file with all verification documents.**
2. **A copy of this form must be scanned and emailed with all scanned verification documents to: Independent Schools Queensland at verification@isq.qld.edu.au.**
3. **Records relating to the application will be retained by Independent Schools Queensland for seven years after the named student leaves school. At that time, the records will be destroyed.**
4. **ISQ has an arrangement for DoE to provide EAP services for eligible students with hearing, physical and/or vision impairment in independent schools. These services are outlined in the EAP Handbook. http://education.qld.gov.au/students/disabilities/adjustment/validation/docs/eaphandbook.pdf**
5. **Information will remain confidential and will not be disclosed without explicit permission.**

Adapted with Permission from Department of Education (DoE) - Queensland Government

STUDENT SUPPORT SERVICES

Consent for student to see Alta-1 College Psychologist/Counsellor/Affiliated Clinical Psychologist

I, _____, (Name of Parent/Guardian) hereby give permission

to Alta-1 College for my child, _____ (Name of Student), to be seen by the Alta-1 College Psychologist, Counsellor and/or Affiliated Clinical Psychologist. By signing this consent form, I have read and agree to the following:

- I understand that these services will incur no additional costs to myself.
- I understand that my child is under no obligation to see the clinical psychologist, Alta-1 psychologist or counsellor and once services have begun, my child may terminate these services at any stage without negative repercussions.
- The services provided include psychological assessments for screening of student wellbeing; diagnostic assessments to apply for Education Adjustment Program funding; ongoing therapeutic support as and when requested by parents/guardians or Alta-1 staff.
- I understand that due to legal and ethical requirements to keep accurate records, the clinical psychologist, Alta-1 psychologist or counsellor may use various methods such as audio recording and written notes.
- Any and all records of the consultations are confidential and remain the property of Alta-1 College, except in the following circumstances:
    - The material is subpoenaed by court; or
    - Failure to disclose certain information would place the student or another person at serious and imminent risk; or
    - Prior approval has been obtained from the student to discuss certain information with another person or provide a report to another professional or agency.
- I undertake responsibility to ensure my child attends booked appointments and to cancel appointments with sufficient notice when my child is unable to attend.
- I understand that my child's personal information will be kept private and will be used solely for purposes of contact with the clinical psychologist, Alta-1 psychologist or counsellor.
- I understand that these services are only available while my child is enrolled as a student of Alta-1 College and will thus cease once my child is no longer enrolled at Alta-1 College.

Parent/Guardian Name:	_____	Student Name:	_____
Signature:	_____	Signature:	_____
Date:	_____	Date:	_____

LETTER TO DOCTOR / SPECIALIST

Dear Doctor / Specialist,

Alta-1 College QLD is a multi-sited Special Assistance School that provides alternative education to 15 to 19 year old students who are educationally disengaged. In appropriate circumstances the College applies for external funding for individual students, in order to provide them with the best educational and therapeutic resources to assist their re-engagement with education and to promote their personal recovery. These funding applications require documented evidence of a student's mental health and/or medical conditions from a relevant health professional.

Typically, students are enrolled into Alta-1 College QLD because they have been unsuccessful in mainstream schooling as a result of personal issues that have impacted their educational engagement. Students may have been excluded from their former schools and some are referred by external support agencies. Many of the students coming to Alta-1 College are dealing with ongoing mental health or medical conditions.

The student presenting to you has applied to enrol at Alta-1 College QLD. For the college staff to be able to provide appropriate support to the student and access additional funding through State and Federal programs, we request a comprehensive letter describing the student's current mental health and/or diagnostic status.

In your letter, please state the following:

- ☐ The name of the student
- ☐ A statement about the student's current mental health condition and whether the student has a verified or imputed diagnosis
- ☐ Anticipated length of diagnosis
- ☐ Any medication the student is currently prescribed
- ☐ Description of how the student's current mental health condition has (or may have) impact the student's ability to attend school
- ☐ Any type of support the student is receiving (counselling, psychologist, other support agencies)
- ☐ Other relevant supporting documents, such as an updated mental health plan

Yours sincerely,

Matthew Vandepeer
Principal

AUTHORITY TO SHARE AND RELEASE INFORMATION

Important information pertinent to your young person is requested to that we can determine how Alta-1 College QLD can best support the student. All information will be kept strictly confidential. Please complete the form below which is asking you to give permission for previous schools and other organisations to release information to Alta-1 College QLD.

Previous School/s	Year Levels	Years Attended

Support Services	Name of Doctor/Agency/Service	Address & Phone Number
Medical Specialist		
Psychologist/ Psychiatrist/ Counsellor/ Mental Healt Services		
Speech Pathologist		
Occupational Therapist		
Other		

Parent/Guardian authorisation:

I hereby authorise Alta-1 College QLD to correspond with relevant organisations (including but not limited to schools, professionals, support agencies, etc.) regarding my child/ward, and for those organization to release any information regarding my child/ward to Alta-1 College QLD.

All information will be kept in the strictest confidence in accordance with the college's Privacy Policy.

Parent/Guardian Name: _____ Student Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

MEMORANDUM OF AGREEMENT

1. I/we acknowledge that the Alta-1 College program is designed to provide a full-time development and education program under the *School Education Act (1999)* (and any amendment to successor legislation).

2. I/we acknowledge that I/we are jointly and severally liable for any contributions stated in each school account relating to the child covered under this application, payable upon receipt of invoice. Arrangements can be made to pay these fees and charges on a weekly basis. I/we agree that if I/we are unable to pay the contributions in full by the time determined that I/we will contact the Administration Office to make alternative arrangements.

3. I/we acknowledge the Christian basis of Alta-1 College. I/we understand that while students are never forced to adopt a particular belief and value system, the Alta-1 College program is delivered from a predominantly Christian perspective. I/we consent to my/our student receiving Christian instruction and, if consented to by my/our student, receiving and/or participating in prayer.

4. I/we irrevocably indemnify Alta-1 College and its representatives against all claims in cases of unforeseen personal injury, or loss of any personal property, at any Alta-1 College site or during any approved activity, including camps, excursions and work placements.

5. I/we understand that due to the unique nature of the Alta-1 College Recovery Curriculum, all students will be placed on Individual Education/Documented Plans, written against their chosen educational pathway.

6. I/we consent to Alta-1 College and its employees administering medication or obtaining medical treatment for the student in the event of an emergency or accident.

7. I/we understand that as part of Alta-1 College program there will be times when staff will take groups of students on impromptu excursions. The excursions may contribute to the educational program or be used to assist in creating a sense of connection with the students. Such excursions may be to places such as a fast food restaurant for food and a chat, or to sites of more explicit educational value such as a museum. As such, I/we give permission my/our child to participate in such excursions and for staff with the appropriate driver's license to use school (and on rare occasions, private) vehicles to transport my/our child.

8. I/we understand that as part of the Alta-1 College educational program, from time to time staff members will screen movies and DVD's carefully chosen for their contribution to the program which, at times, may carry an M, or on rare occasions an MA rating, for which I/we give my/our permission for my/our child to view.

9. I/we understand that Alta-1 College offers a voluntary Student Therapeutic Services program, as detailed in the Parent Handbook. I/we give permission for my/our child to participate in this program, on the understanding that I/we can withdraw this permission at any time by contacting the Alta-1 College Administration Office.

10. I/we understand that from time to time my student may have interaction with Alta-1 College staff members outside of school hours through mentoring, church, youth group or other such events. I understand this interaction is purely voluntary. I also understand in such hours of interaction Alta-1 College staff members may drive my student either in a private or Alta-1 College vehicle, at which times it will be expected that Alta-1 College staff members continue to abide by relevant Alta-1 College policies.

11. I/we accept that if my/our student fails to demonstrate satisfactory progress in the program a panel will meet to discuss our future in the Alta-1 College program, and we agree to accept and not challenge in any way the decision of the panel as to whether we are to be permitted to remain involved in the program, the conditions under which my/our student will be permitted to remain, or whether my/our student is required to cease all involvement in the program.

12. I/we confirm that all information provided regarding my/our child's enrolment is accurate and complete, and all relevant documents have been provided in accordance to the Application Checklist. I/we understand that failure to provide accurate and/or complete information may render this Memorandum of Agreement null and void.

13. I/we have read, understood and agree to abide by the above conditions of this Agreement. I/we consent to all approvals of this application.

Parent/Guardian 1 Signature: _____ Parent/Guardian 2 Signature: _____

Student Signature: _____ Principal Signature: _____

CONSUMABLES CONTRIBUTION (LEVY) INFORMATION

Dear Parent/Guardian,

Thank you for entrusting Alta-1 College QLD with the education of your child/dependent.

Many independent schools charge school fees, however Alta-1 College QLD does not do so at the present time. Nonetheless the College does ask parents/guardians for a financial contribution towards items that are consumed in the day to day of their child's education. This contribution by parents and guardians is called a Consumables Contribution (or Consumables Levy).

To provide some insight, the following list details some of the items that are covered by the contribution:

- Stationery & student learning materials (e.g. pens, pencils, rulers, calculators, glue sticks, exercise books, journals, textbooks, reading materials)
- Paper and printing
- Some kitchen/electrical appliances (e.g. students have access to kettles, microwave, toaster, fridge/freezer)
- Fuel (e.g. fuel for regular student outings and excursions)
- Food (e.g. staples that are supplied by the College for all students)
- The cost of running Afternoon Electives for students

The contribution is also used to supplement costs for the enrolment of students in various aspects of the College program. Student participation in the Duke of Edinburgh Award and the Certificate II in Skills for Work and Vocational Pathways all has associated registration fees that the College supports.

The Consumables Contribution is $100 per student per term. Across 40 school weeks it equates to a modest $10 per week.

The best way that you can pay the contribution is by Direct Debit. Alternatively, you can speak with a member of the College Administration who can assist you with other payment options.

For your benefit there is a Direct Debit Request Form on the following page.

It is important to note that financial hardship should not prevent any young person from attending Alta-1 College QLD and no young person will be denied an Alta-1 College education because of a family's genuine inability to pay the Consumables Contribution.

Applications for assistance with the Consumables Contribution should be made in writing to:

The Principal – Matthew Vandepeer
Alta-1 College QLD
PO Box 388
CABOOLTURE, QLD, 4510

Or Email: admin@alta-1.qld.edu.au

Thank you for your continuing commitment and contribution to Alta-1 College QLD.

Yours sincerely,

Matthew Vandepeer
Principal

DIRECT DEBIT REQUEST

Request and Authority to debit the account named below to pay Alta-1 College (QLD) Ltd

Request and Authority to debit

Your Surname or company name _____

Your Given names or ABN /ARBN _____ "You"

Student/s full name _____ Site: _____

request and authorise **Alta-1 College (QLD) Ltd and User ID: 529157** to arrange, through its own financial institution, a debit to Your nominated account any amount **Alta-1 College (QLD) Ltd**, has deemed payable by You.

This debit or charge will be made through the Bulk Electronic Clearing System (BECS) from Your account held at the financial institution You have nominated below and will be subject to the terms and conditions of the Direct Debit Request Service Agreement.

Insert the name and address of financial institution at which account is held

Financial institution name _____

Address _____

_____

Insert details of account to be Debited

Name/s on account _____

BSB number (Must be 6 Digits) __ __ __ - __ __ __

Account number

_____

☐ Weekly ☐ Fortnightly ☐ Monthly **(Please tick appropriate payment frequency)**

Acknowledgment

By signing and/or providing us with a valid instruction in respect to Your Direct Debit Request, you have understood and agreed to the terms and conditions governing the debit arrangements between You and **Alta-1 College (QLD) Ltd** as set out in this Request and in Your Direct Debit Request Service Agreement

Insert Your signature and address

Signature_____
(If signing for a company, sign and print full name and capacity for signing eg. director)

Address

_____

Date __ __ / __ __ / __ __ __ __

Second account signatory

(if required)

Signature _____
(If signing for a company, sign and print full name and capacity for signing eg. director)

Address _____

Date __ __ / __ __ / __ __ __ __

ASTHMA CARE PLAN FOR EDUCATION AND CARE SERVICES

PHOTO OF STUDENT (OPTIONAL)

CONFIDENTIAL: Staff are trained in asthma first aid (see overleaf) and can provide routine asthma medication as authorised in this care plan by the treating doctor. Please advise staff in writing of any changes to this plan.

To be completed by the treating doctor and parent/guardian, for supervising staff and emergency medical personnel.

Plan date
___/___/20__

Review date
___/___/20__

PLEASE PRINT CLEARLY

Student's name: _____ DOB: _____

MANAGING AN ASTHMA ATTACK

Staff are trained in asthma first aid (see overleaf). Please write down anything different this student might need if they have an asthma attack:

_____

_____

_____

DAILY ASTHMA MANAGEMENT

This student's usual asthma signs:

- ☐ Cough
- ☐ Wheeze
- ☐ Difficulty breathing
- ☐ Other (please describe): _____

Frequency and severity:

- ☐ Daily/most days
- ☐ Frequently (more than 5 x per year)
- ☐ Occasionally (less than 5 x per year)
- ☐ Other (please describe) _____

Known triggers for this student's asthma (e.g. exercise*, colds/flu, smoke) — please detail:

_____

_____

_____

_____

_____

Does this student usually tell an adult if s/he is having trouble breathing?	☐ **Yes**	☐ **No**
Does this student need help to take asthma medication?	☐ **Yes**	☐ **No**
Does this student use a mask with a spacer?	☐ **Yes**	☐ **No**
*Does this student need a blue/grey reliever puffer medication before exercise?	☐ **Yes**	☐ **No**

MEDICATION PLAN

If this student needs asthma medication, please detail below and make sure the medication and spacer/mask are supplied to staff.

NAME OF MEDICATION AND COLOUR	DOSE/NUMBER OF PUFFS	TIME REQUIRED

DOCTOR

Name of doctor _____

Address _____

Phone _____

Signature _____ Date _____

PARENT/GUARDIAN

I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to staff and emergency medical personnel. I will notify the staff in writing if there are any changes to these instructions. I understand staff will seek emergency medical help as needed and that I am responsible for payment of any emergency medical costs.

Signature _____ Date _____

Name _____

EMERGENCY CONTACT INFORMATION

Contact name _____

Phone _____

Mobile _____

Email _____

For asthma information and support or to speak with an Asthma Educator call **1800 ASTHMA** (1800 278 462) or visit **asthma.org.au**

ASTHMA AUSTRALIA

Date of approval: June 2018 | Approved by: CEO Asthma Australia | Date of review: June 2018 | AACPED2018 Care Plan for Schools A4 | 6 June 2018

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Allergic Reactions

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

1. _____

Mobile Ph: _____

2. _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises medications specified on this plan to be given according to the plan, as consented by the patient or parent/guardian, including use of adrenaline if available.

Whilst this plan does not expire, review is recommended by DD/MM/YY

Signed: _____

Date: _____

Note: This ASCIA Action Plan for Allergic Reactions is for people who have allergies but do not have a prescribed adrenaline (epinephrine) injector. For instructions refer to the device label or the ASCIA website www.allergy.org.au/anaphylaxis

Adrenaline injectors are given as follows:

- 150 mcg for children 7.5-20kg
- 300 mcg for children over 20kg and adults
- 300 mcg or 500 mcg for children and adults over 50kg

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person and call for help
- Give antihistamine (if prescribed) _____
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult or noisy breathing**
- **Swelling of tongue**
- **Swelling or tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- **If unconscious or pregnant, place in recovery position - on left side if pregnant, as shown below**
- **If breathing is difficult allow them to sit with legs outstretched**
- **Hold young children flat, not upright**

2 GIVE ADRENALINE INJECTOR IF AVAILABLE

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE INJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS GIVE ADRENALINE INJECTOR FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

Note: If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

© ASCIA 2021 This plan was developed as a medical document that can only be completed and signed by the patient's doctor or nurse practitioner and cannot be altered without their permission.

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www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

For use with adrenaline (epinephrine) injectors

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

1. _____

Mobile Ph: _____

2. _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises medications specified on this plan to be given according to the plan, as consented by the patient or parent/guardian.

Whilst this plan does not expire, review is recommended by DD/MM/YY

Signed: _____

Date: _____

Refer to the device label for instructions on how to give an adrenaline (epinephrine) injector.

Instructions are also on the ASCIA website www.allergy.org.au/anaphylaxis

Adrenaline injectors are prescribed as follows:

- 150 mcg for children 7.5-20kg
- 300 mcg for children over 20kg and adults
- 300 mcg or 500 mcg for children and adults over 50kg

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person, call for help and locate adrenaline injector
- Give antihistamine (if prescribed) _____
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult or noisy breathing**
- **Swelling of tongue**
- **Swelling or tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- **If unconscious or pregnant, place in recovery position - on left side if pregnant, as shown below**
- **If breathing is difficult allow them to sit with legs outstretched**
- **Hold young children flat, not upright**

2 GIVE ADRENALINE INJECTOR

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Further adrenaline may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE INJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS GIVE ADRENALINE INJECTOR FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

Note: If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

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