



YEAR 6 CAMP 2024

To Parent/Carers

The purpose of our Year 6 Camp is for our students to enjoy a shared, inclusive experience in a new environment, so that students develop resilience, independence, and teamwork whilst also having fun. While on camp, students enhance their leadership skills and awareness of themselves and others. They participate in activities to improve their problem-solving abilities and communication skills. Through this shared experience, the students make new friends, are challenged, and have the opportunity to provide support to each other.

On camp, students participate in a range of activities that they may not usually have access to in their day-to-day schooling. This is a perfect opportunity for students to get out of their comfort zone and to take risks while being surrounded by their supportive peers.

In the past, a number of students have opted out of attending camp. While the decision is ultimately made between you and your child, it is important to consider the personal gains, memories, the new friends that are made and the celebrations together. In previous years, feedback has generally suggested that in the end, these outweigh any nerves or anxiety the students may have leading up to it. Camp is always a memorable experience, and remains a topic of conversation for days, weeks, months and years after it takes place.

Next year, Year 6 Camp will be held in **Week 5, Term 1**. The students will depart West Byford Primary School (WBPS) on **Wednesday, 28th February and return on Friday, 1st March**. The decision to run camp this early in the year was made to allow the students a full year to implement the skills they learn on camp and build upon the new friendships they create. Organising a camp with a large group of students is a massive undertaking and can only be possible if we collect information and payment from families this year.

The WBPS Year 6 Camp is a wonderful opportunity, an important transition, and a privilege. We are all very much looking forward to sharing this experience with your child.

LOCATION: Nanga Bush Camp, Dwellingup

TRANSPORT: Bus with seatbelts

COST: \$440 per student.

Full payment is due no later than Wednesday, 21st February 2024. Our Front Office is open the week prior to students returning. If you foresee difficulties paying the full amount by this date, please contact Danielle Kneafsey, Manager Corporate Services, to discuss a payment plan. She can be emailed on danielle.meyn@education.wa.edu.au.

Documentation, including medication forms, is due no later than Friday, 2nd February 2024, the end of Week 1. Due to the amount of work and information needing to be collated, **late payments and permission forms may not be accepted.**

Payment can be made by direct deposit, over the phone by credit card, or in person at the Front Office by card or cash. Please note, change will not be provided for cash payments and any change owed will be listed as credit on your child's account.



If you wish to pay by direct deposit, the bank account details are:

Account Name: West Byford Primary School

BSB: 066 040

Account number: 1990 4111

Reference: Surname FirstInitial Class Y6Camp (for example Smith A X1 Yr6Camp) – **please ensure your child's surname, initial and class are included at the start of the reference as we get numerous payments throughout the day. There may be a delay in matching your payment to your child if this information is missing.**

STUDENT HEALTH CARE FORMS AND MEDICATION

We require an updated Form 1 – Student Health Care Form for every student, which can be found attached to this letter.

For staff to be able to give out medication, including Panadol and Nurofen, parents must complete Form 3 – Administration of Medication and supply the medication as listed. Please see the form attached to this letter.

SUPERVISORY TEAM: Year 6 Classroom Teachers, allocated Education Assistants, parent volunteers, Deputy Principal, Principal

PARENT VOLUNTEERS

We will need five parent volunteers to assist from Wednesday, 28th February to Friday, 1st March. If you would like to volunteer, an Expression of Interest form has been included. These forms need to be returned by Friday, 2nd February 2024. Please note, due to the camp having an overnight stay component, parent volunteers **must hold** a valid Working with Children Check card. Application and renewal receipts are no longer accepted, and a valid check must be in place. Please provide a copy of your valid WWCC card when lodging your Expression of Interest.

TUESDAY 27th FEBRUARY ACTIVITIES

Before the Year 6 students leave for the camp, they will be brought together for a day of activities surrounding team building.

If you have any questions regarding the Year 6 Camp, please don't hesitate to contact me by email chloe.scardetta@education.wa.edu.au or by phoning 9526 6550.

Kind regards

Chloe Scardetta
Year Six Teacher

21 November 2023

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Kardan Boulevard
Byford WA 6122
Phone 9526 6550
Email westbyford.ps@education.wa.edu.au



This form and the Student Health Care Summary needs to be filled in and returned to the Front Office/Administration by Friday, 2nd February 2024

DIETARY REQUIREMENTS

Please tick the box(s) that apply.

- My child has no dietary requirements
- Peanut Allergy Tree Nut Allergy Egg Allergy Milk/Dairy Allergy
- Seafood Allergy Sesame Allergy Coeliac Disease Soy Allergy
- Fish/Shellfish Allergy Sesame Allergy Vegetarian Vegan
- Gluten/Wheat Intolerance Other (Please Specify):

Do you require Halal or Kosher meals? YES NO

Other requirements not listed (please specify):
.....
.....
.....

YEAR 6 CAMP PERMISSION

I give permission for my child _____ to attend the Year 6 Camp occurring 28th February – 1st March 2024.

I confirm I have read all information as outlined in the letter and discussed all information with my child. I confirm the information on the enclosed Student Health Care Summary form is correct.

Payment Options (tick one)

I confirm the camp will be paid in full no later than Wednesday, 21st February 2024.

OR;

I am requesting a payment plan and will make contact with Danielle Kneafsey.

Parent name: _____

Parent signature: _____

Date: _____

Kardan Boulevard
Byford WA 6122
Phone 9526 6550
Email westbyford.ps@education.wa.edu.au



PARENT HELPER EXPRESSION OF INTEREST

Please sign and return this form to your child’s classroom teacher by Friday, 2nd February 2024.

I, _____, parent/carer of _____
would like to volunteer to be a parent helper at the 2024 Year 6 Camp from Wednesday, 28th
February to Friday, 1st March 2024.

I understand the following, prior to attending the camp (please tick):

I will not receive remuneration for volunteering.	<input type="checkbox"/>
All food, accommodation and transport will be provided (with the exception of morning tea, lunch and afternoon tea on the first day).	<input type="checkbox"/>
I won't be in the same grouping as my child.	<input type="checkbox"/>
I will not leave the camp, unless there is an emergency.	<input type="checkbox"/>
The decision of which parents attending camp is final and decided by staff and Administration.	<input type="checkbox"/>
<i>If successful, I will need to follow and sign the WBPS Code of Conduct.</i>	<input type="checkbox"/>
<i>If successful, I will need to provide a copy of my Working With Children Check (WWCC).</i>	<input type="checkbox"/>
<i>If successful, I will need to provide a copy of my Health Care Summary.</i>	<input type="checkbox"/>

Please attach a copy of your WWCC card to this Expression of Interest. An Expression of Interest cannot be accepted without a copy attached.

Please provide the following information:

Current occupation: _____

School camp experience (if any):

School volunteer experience (if any):

Parents who have expressed interest will be notified with an email if they are successful or unsuccessful. We appreciate your ongoing support with our school events!

Parent Signature: _____

Date: _____



Student Health Care Summary Form 1

SECTION A

Year Form/Class Teacher

Preferred Name

Date of birth (dd/mm/yy) Gender Male Female Other

Address Postcode

FAMILY CONTACT DETAILS

Contact 1

Name

Relationship to student

Address Postcode

Telephone (Home) Telephone (Work)

Telephone (mobile)

FAMILY CONTACT DETAILS (Continued)

Contact 2

Name

Relationship to student

Address

Postcode

Telephone (Home)

Telephone (Work)

Telephone (mobile)

MEDICAL DETAILS

Medical practice

Doctor 1

Telephone

Doctor 2

Telephone

Do you have ambulance insurance?

Yes

No

If yes, specify insurance provider

If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance.

List any essential information that could affect your child in an emergency eg allergy to penicillin.

Medicare Card Number

Medicare Card Individual Reference Number (IRN)

Expiry date (dd/mm/yy)

...../...../.....

ADMINISTRATION OF MEDICATION

Written authorisation must be provided to staff to administer any form of medication at school.

Long term medication – Complete the *Medication section* of the relevant health care plan – see below.

Short term medication – Request an *Administration of Medication form* to complete and return to the Front Office.

Note: All medication required must be supplied by parents/carers.

INFORMED CONSENT

Your child's health care information will be shared with staff on a need to know basis unless otherwise stated.

Do you give permission for the school to share your child's health care information?

Yes

No

Note: If your child is enrolled in a TAFE, PEAC or an alternative education programs, this includes the transfer of their health care information to the principal or manager of that program.

If no, and the information is to be restricted, who can be informed of your child's health care information?

Does your child have one or more health condition(s) that will require support from school staff? (Check the box that applies)

NO – Sign below and returned *Section A* of this form to the school office. If your child's requirements change, please notify the school.

Signature

Date

...../...../.....

YES – complete Section B, Section C and Section D and return to the school office. You will be given additional forms to complete.

List your child's health condition(s)

SECTION B

IN THE FOLLOWING TABLE, PLEASE INDICATE YOUR CHILD'S CONDITION(S) WHICH REQUIRE THE SUPPORT OF SCHOOL STAFF

(In response to the information below, you will be given further forms for specific health conditions to complete)

Health conditions (Check the box that applies)

- Severe Allergy/Anaphylaxis
- Minor and Moderate Allergies
- Diabetes
- Seizures
- Asthma
- Activities of Daily Living
- Other Conditions or Needs** (Please specify below)

Will school staff require specific training to support your child?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Has your child's Medical Practitioner provided a health care plan to assist the school to manage the condition?

Yes No

If you have ticked Yes for specific staff training above, please discuss the type of training needed with the Principal.

SECTION C – CONSENT FOR PHOTO IDENTIFICATION ON YOUR CHILD'S HEALTH CARE PLAN

If your child has a condition where an emergency may occur, please indicate whether you give consent for staff to place your child's medical details and photo on view to provide immediate identification.

I give permission for my child's medical details and photo to be on view for staff.

Yes No

If yes, please attach photo to the relevant health care plan(s).

SECTION D – MEDIC ALERT INFORMATION

Does your child have a Medic Alert bracelet or pendant?

Yes No

If yes, provide details below:

Parent/Carer Name

Parent/Carer Signature

Date/...../.....

ON COMPLETION OF THIS FORM, PLEASE REQUEST AND COMPLETE THE RELEVANT HEALTH CARE PLANS.

Note: Where appropriate students should be encouraged to participate in their health care planning.

OFFICE USE ONLY

Does the child have an allergy that needs to be flagged on SIS?

Yes No

Date/...../.....

Have the relevant health care plans been issued to the parent?

Yes No

Date/...../.....

Has the Principal been informed if:

-Specific training is required to support the student?

Yes No

-The student's health care information is to be restricted?

Yes No

Date Student Health Care Summary was completed and uploaded on SIS:

...../...../.....

FORM 3 - ADMINISTRATION OF MEDICATION

This form is to be used when a parent/carer requests school staff to administer medication to their child on a short term basis.

Note: Long term administration of medication should be incorporated in a health care plan.

School: West Byford Primary School Year: Form:

Student's Name: Date of Birth: Gender:

Family Contact Details
Address:

Telephone No: Teacher:

Section A: Medication Instructions – To be completed by parent/carer (Note: Medication must be provided by parents/carers)

	Medication 1		Medication 2	
Name of medication				
Expiry date				
Dose/frequency – (may be as per the pharmacist's label)				
Duration (dates)	From : 28/02/2023 To: 01/03/2023		From : 28/02/2023 To: 01/03/2023	
Route of administration				
Administration Tick appropriate box	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>		By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>	
Storage instructions Tick appropriate box(es)	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>		Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>	

Will staff need to be trained to administer your child's medication? Yes No If yes, describe the type of training the staff would require:

Section B – Authority to Act

This administration of medication form authorises school staff to follow my/our advice and/or that of our medical practitioner. It is valid for the specified time period as noted above.

Parent/Carer: _____ Date: _____

OFFICE USE ONLY

Date received: _____

Is specific staff training required? Yes No : Type of training: _____

Training service provider: _____ Name of person/s to be trained: _____

Date of training: _____

When this course of medication concludes, please retain this form in the student's school file.