23rd October, 2014

TOOTGAROOK PRIMARY SCHOOL
Grade 2 Sleepover

ARRANGEMENTS for SLEEPOVER

**Thursday 27th:** 3:30pm
Go home, SHOWER, collect gear, **return at 5.30pm**.
Please help your child to set up before leaving.
**GIRLS in the library & BOYS in the Multi-Purpose Room.**

6:00pm
Tea, games, beach walk (weather permitting),
supper, story, sleep.
Lynne Baird, Donna Johnstone, Graham Sharrock & a male teacher will be on duty overnight with the children.

**Friday 28th:**
7:00am
Breakfast
8:30-9.00
**PARENTS TO PICK-UP BEDDING, IF POSSIBLE from Grade 2 area**
8:45
Assemble in Multi-Purpose Room
9:00
Travel by bus to Sorrento Park
11:00
Travel by bus to Beach opposite Truemans Rd
12:00pm
BBQ lunch
1:30
Return to school
2:00pm
Dismissal from school

Collect bedding etc. from Grade 2 area if not already collected.

WHAT YOU NEED:

**Gear:** (Please LABEL all articles)

- Sleeping bag and pillow (sheet optional)
- Airbed, with foot pump, or foam mattress
- Hairbrush or comb
- Clothing suitable for walking, socks and shoes, no thongs
- Pyjamas
- Change of underwear
- Toothbrush and toothpaste
- Soap, face washer & hand towel
- Plastic cup, spoon, bowl (named & in a bag)
- School hat & sunscreen
- Plastic bag for dirty clothes
- Water bottle named.
- **PLEASE NO** sleeveless tops
- **NO HAT, NO GO!!**

Yours sincerely,

Wayne WHITWORTH
Principal

Lynne BAIRD & Donna JOHNSTONE
Class Teachers
23rd October, 2014

TOOTGAROOK PRIMARY SCHOOL GRADE TWO SLEEPOVER

Dear Parents,
As an introduction to the School Camping Program the grade two children will be having a SLEEPOVER at the school on Thursday, November 27th.

This will be followed by a visit to Sorrento Park and beach activities at Toogarook Beach on Friday 28th November.

DATES: Thursday November 27th to Friday November 28th
TIMES: 5:30pm Thursday until 2:00pm Friday

COST: $18.00

E.M.A. MAY BE USED FOR THIS CAMP BUT PLEASE CHECK YOUR BALANCE AT THE OFFICE FIRST
If your child requires any medication, please label it and hand to Mrs Baird on arrival. This includes asthma medication.

Yours sincerely,
W. WHITWORTH
Principal

Lynne BAIRD & Donna JOHNSTONE
Class Teachers

PLEASE RETURN THIS SIGNED PERMISSION FORM, WITH PAYMENT AND MEDICAL FORMS BY FRIDAY NOVEMBER 7th, 2014

TOOTGAROOK PRIMARY SCHOOL
GRADE TWO SLEEPOVER

I GIVE PERMISSION FOR MY CHILD ............................................................GRADE .............. TO ATTEND THE GRADE TWO SLEEPOVER ON THURSDAY 27th & FRIDAY 28th NOVEMBER, 2014.

☐ I ENCLOSE $18.00.

☐ I WISH TO PAY WITH EMA & I HAVE CHECKED WITH THE OFFICE

My child ........................................will be picked up at 2:00pm on Friday 28th by

...........................................

Parent’s signature ..........................
**TOOTGAROOK PRIMARY SCHOOL**
**CAMP**
**Confidential Student Medical Information**

(Please complete and return as soon as possible)

This information is intended to assist the school in case of any medical emergency with your child. All information is held in confidence.

Child's Name: ..............................................................................................................

Date of Birth: ........................................... School Year: ..............................................

Parent's/Guardian's Full Name: ......................................................................................

Emergency Telephone: After Hours: .................................................................

Mobile: ................................................ Bus. Hours: ..................................................

Name of Family Doctor: ..............................................................................................

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Medication to be taken during camp – please note that the staff at the camp can only give medication to children that is contained in dispensed pharmacy packaging with the child’s name, dose and expiry date. Please complete separate Asthma Management Plan Sheet if your child suffers from asthma.

Medication (1) ...............................................................................................................

Dosage (1) ........................................ (mgs/mls/puffs/tabs) Times (1) .........................

Medication (2) ...............................................................................................................

Dosage (2) ........................................ (mgs/mls/puffs/tabs) Times (2) .............................

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Please help us to understand your child’s general health status by circling ‘yes’ or ‘no’ to the following:

- A.D.D./A.D.H.D. Yes/No
- Bedwetting Yes/No
- Blackouts Yes/No
- Diabetes Yes/No
- Dizzy spells Yes/No
- Epilepsy/Fits Yes/No
- Heart Yes/No
- Migraines Yes/No

Condition: Please explain: ..........................................................................................

If your child has asthma, even occasionally, you must complete an asthma management form.

Other Yes/No

If you answered ‘yes’ to the allergies question above, please describe your child’s condition, any signs and symptoms of the allergy or sensitivity and how you would prefer our staff to respond.

**Medication**

What happens? .............................................................................................................

**Treatment** .............................................................................................................
Foods ..............................................................................................................................
What happens? ..................................................................................................................
Treatment ..........................................................................................................................
Other ................................................................................................................................
What happens? ..................................................................................................................
Treatment ..........................................................................................................................

Medicare No. .............................................. Expiry date ................. Child’s no. on card ..............
Private Health Insurer ................................................... Private Health Care No. ...................
Ambulance Subscriber Yes / No Subscriber no. .................................................................
Child’s last tetanus injection ....................(year) Are all immunizations up to date? Yes / No
Is this the first time your child has been away from home? Yes / No

CONSENT TO MEDICAL ATTENTION

Where the teacher in charge of the camp is unable to contact me, or it is otherwise impracticable to contact me, I authorise the teacher in charge to:
• consent to my child receiving such medical or surgical attention as may be deemed necessary by a medical practitioner,
• administer such first-aid as the teacher in charge may judge to be reasonably necessary.

Signature of Parent/Guardian: .......................... Date: ......................................................

The Department of Education requires this consent to be signed for all students attending school excursions.