CAAPS

Council for Aboriginal Alcohol Program Services
Aboriginal Corporation

PRIVACY AGREEMENT
PERMISSION TO PUBLISH OR DISPLAY PHOTOGRAPHS/ VIDEO

This form covers privacy issues for photographs, videos and artwork. It is not a licence agreement and does not address copyright issues.

	Display		Print		Web		Video	
Description of work	**self**	**other**	**self**	**other**	**self**	**other**	**self**	**other**
Photographs								
Videos								
Art work								
Other (please describe)								

I_____, agree/disagree to the above being used by CAAPS for display or publication (please tick above for consent).

As legal guardian of the children listed below, I agree/disagree to the above being released.

_____ _____

_____ _____

I understand that at any time I may withdraw my consent at anytime by advising CAAPS staff.

Signature:_____Date:___/_ /___

CAAPS Staff member name: _____

Signature:_____Date:___/_ /___

This information will be stored at CAAPS a record of permission to take/ publish photographs or video. The information should not be used for other purpose. For queries about CAAPS information and Privacy Policies, contact CAAPS on (08) 8922 4800.

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General Program Consent (Unaccompanied Minor)

Client Information	
Family Name	Given Name
Date of Birth __/__/_____	Gender (circle) Male Female

General Information
Does the client have any medical, psychological or behavioural issues that may impact program attendance? If so please state the issues and describe how the issues are managed
Is the client capable of swimming in deep water unassisted? Yes No ..... if No How would you describe your child swimming ability? (circle) Can't swim at all Can stay afloat in water Can swim a few strokes
Is there any other information which could assist CAAPS in helping your child participate in the CAAPS program?

Please read the following important points:

- If the client is expected to participate in any activity where they will spend 1 night or more away from CAAPS facility, guardians will be notified where possible prior to the activity taking place.
- Staff supervision is always provided during all program activities, however should a client require additional support to participate in activities CAAPS may exclude the client from activities if additional support is not available at the time of the activity taking place.

Consent		
Permission is given for the client to attend program activities on and away from the CAAPS facility	YES	NO
Permission is given for the client to participate in swimming activities under the supervision of staff	YES	NO
Permission is given for staff to transport clients in CAAPS vehicles	YES	NO
Permission is given for the client to attend overnight camps away from CAAPS facility	YES	NO

I understand the nature of adventure recreation camping programs and the risks involved. I have discussed the program with staff and clarified any areas of concern prior to signing this consent form. I give consent for . . . . . to attend the adventure recreation camping program. In case of emergency I allow CAAPS staff to seek medical assistance for him/ her. Name: . . . . . . Relationship: . . . . . . Signature:		

Name: _____ **Signature:** _____ **Date:** __/__/__

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General Medical Consent (Unaccompanied Minor)

Client Information		
Family Name		Given Name
Date of Birth __/__/____		Gender (circle) Male Female
Medicare Number		Health Care Card Number
Guardian Information		
Is the client under a current care order with the Minister? No Yes		
Guardian name	Relationship to child	Phone W: H: M:
Emergency Contact (additional to guardian details)		
Name	Relationship to child	Phone W: H: M:
Medical Details		
Known allergies _____ _____ _____ Is the client medicated? Yes No		Dietary restrictions Date of last tetanus injection __/__/____
Current medication Name Dose Time Reason for medication 1. 2. 3.		
Does the client have any medical condition, physical or psychological limitations or cultural restrictions which may affect her/him taking part in the program and/or activities? Please provide full details (attach information if necessary). Please provide any other information which you believe may help staff provide the best possible care. _____ _____ _____		

Please read the following important points:

- All Clients will receive an initial medical consultation as soon after admission as practical
- All medications are stored securely on CAAPS premises and staff assist clients with any required medication as prescribed by a medical doctor
- Clients will be transported to medical appointment in CAAPS vehicles.

Consent		
Permission is given to seek medical attention in case of illness/accident whilst in the program	YES	NO
Permission is given for staff to administer first aid and medication if required	YES	NO
Permission is given for my child to attend medical appointments and undertake treatment whilst in the program	YES	NO
Permission is given for my child attend and undertake dental treatment required whilst at CAAPS	YES	NO
Permission is given for my child to undertake pathology testing (e.g. blood test) if required by a doctor	YES	NO
Permission is given for CAAPS staff to assist my child with taking prescribed medication if required.	YES	NO
Permission is given for my child to be provided with Paracetamol for temporary pain relief	YES	NO

Name: _____ **Signature:** _____ **Date:**__/__/__

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Consent to Care - (Unaccompanied Minor)

Client Information	
Family Name	Given Name
Date of Birth __/__/_____	Gender (circle) Male Female

Guardian Information		
Is the client under a current care order with the Minister? No Yes		
Guardian name	Relationship to child	Contact details W: H: M:

Please read the following important points:

- If another agency is requesting information regarding the client which does not relate to their current participation in the CAAPS program, staff will request permission from you in writing before providing any information (this excludes statutory information sharing e.g. DCF, Mandatory Reporting).
- Staff supervision is always provided for underage clients during outings and appointments.

Consent		
Permission is given for the client to attend therapeutic program activities on and away from the CAAPS facility	YES	NO
Permission is given for staff to CAAPS staff to make appropriate referrals on behalf of the client to other services that will enhance the clients participation in CAAPS program.	YES	NO
Permission is given for my child to attend appointments or activities with other service providers as part of their participation in CAAPS programs	YES	NO
Permission is given for staff to contact other agencies and request information concerning my child	YES	NO
Permission for given for staff to provide daily care and direction to the client as part of the residential program	YES	NO

Name: _____ **Signature:** _____ **Date:** __/__/__

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RELEASE OF INFORMATION (ROI)

Name		Date of Birth	

I hereby authorise information regarding my background (including health, home life, legal status, etc.) to be exchanged between the Council for Aboriginal Alcohol Program Service Aboriginal Program and

Organisation Name	
Organisation Name	
Organisation Name	

Any information exchanged will only be used to assist in providing appropriate service support and will not be given to any other programme or person without written permission.

Client & Worker Details	**Date**	
Client Signature		
Worker's Name		
Worker's Signature		

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CONSENT TO COLLECT AND STORE DATA

Clients Name		Date of Birth	
Address			

I hereby authorise information regarding my background (including health, home life, legal status, etc.) to be collected and stored on the CAAPS Data Base and the government Data Base Ship to Shor for reporting purposes.

Client Signature		Date	
Requesting Staff Member			
Worker's Signature		Date	

Any information exchanged will only be used to assist in providing appropriate service support and will not be given to any other programme or person without written permission.