Cultivate Discipleship Programme
New Zealand
Wahi Tapu o Kawari Putahio Paipera o Aotearoa
PO Box 302 659
North Harbour, Auckland 0751
New Zealand
Email: cultivateadmin@ccbi.ac.nz
www.cultivate.kiwi

PARENTAL/ GUARDIAN CONSENT FORM

STUDENT INFORMATION *(Please print clearly)*

Full Name: *(Last)* _____ *(First)* _____ *(Middle)* _____

Address *(Street and Box No.)*:
_____

City: _____ State/ Country: _____ Postcode: _____

Phone Number: (_____)_____

Medical Alert Number *(if applicable)*: _____

Name of Family Doctor: _____

Address *(Street and Box No.)*: _____

City: _____ State/ Country: _____ Postcode: _____

Phone Number: (_____)_____

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact *(Parent/ Guardian filling out this form)*:

First Name: _____

Last Name: _____

Email: _____

Phone Number: (_____)_____

Address *(Street and Box No.)*:
_____

City: _____

State/ Country: _____

Postcode: _____

Relationship to Student: _____

Secondary Emergency Contact:

First Name: _____

Last Name: _____

Email: _____

Phone Number: (_____)_____

Address *(Street and Box No.)*:
_____

City: _____

State/ Country: _____

Postcode: _____

Relationship to Student: _____

To be read and signed by Parent/ Guardian of Student.

Parental/ Guardian Consent

I agree to my son/ daughter taking part in the Cultivate Discipleship Programme. I agree to his/her participation in the activities described. I acknowledge the need for him/her to behave responsibly.

I agree that my sons/ daughter written evaluation of the programme, group stories, videos or photographs may be used in publications associated with the organisation. Publications may include newsletters, annual reports, websites, Facebook and other social media platforms.

Acknowledgment of Risk

I understand that there are risks associated with any involvement in a youth programme and that these risks cannot be completely eliminated. I understand that the Cultivate Discipleship Programme will identify any foreseeable risks or hazards and implement correct management procedures to eliminate, isolate or minimise those hazards. I understand my son/ daughter will be briefed with these safety and emergency procedures that pertain to the Cultivate Discipleship Programme. I will do my best to ensure that my son/ daughter follows these procedures.

I know that I am able to ask any questions of the Cultivate Discipleship Programme about the activities my son/ daughter will be involved in to gain a better understanding of the risks involved. I recognise that participation in such activities is voluntary and not mandatory through a 'challenge by choice'* procedure. My son/ daughter and I both understand that he/ she may withdraw from an activity if he/ she feels at risk. This must be done in consultation with the Cultivate director.

I understand that the Cultivate Discipleship Programme does not accept responsibility for loss or damage to personal property and that it is my responsibility to check my own insurance policy.

*'challenge by choice' means the participant chooses their own level of challenge within a supportive peer environment.

Name of Parent/ Guardian: _____

Signature: _____ Date: _____

MEDICAL/DIETARY INFORMATION

The information on this form will, in general, remain confidential to the Cultivate Staff assisting with this programme. However, in the interests of the safety of all involved, any life threatening conditions may have to be made known to other Students. Please be assured that your son/ daughter's physical and emotional well-being remains of paramount importance to us at all times.

Does your son/ daughter wear a Medic Alert Bracelet? If so, what is the number and where is it worn?

_____

_____

1. Please tick if your son/daughter has any of the following:

☐ Migraine ☐ Epilepsy ☐ Asthma

☐ Diabetes ☐ Travel sickness ☐ Fits of any type

☐ Chronic nose bleeds ☐ Heart condition ☐ Dizzy spells

☐ Color blindness ☐ Anaphylaxis ☐ Other (please specify): _____

As your son/daughter will be rooming with other Students, please provide information on any relevant issues:

☐ Sleepwalking ☐ Snoring ☐ Sleep Apnea

2. Is your son/ daughter currently taking medication(s)? If yes, please provide the details below.

☐ Yes ☐ No

Medication 1:

Name of Medication: _____

Reason for medication: _____

Dosage and time(s) to be taken: _____

Additional information *(if necessary)*:
_____

_____

Medication 2 *(if necessary)*:

Name of Medication: _____

Reason for medication: _____

Dosage and time(s) to be taken: _____

Additional information *(if necessary)*:
_____

_____

Medication 3 *(if necessary)*:

Name of Medication: _____

Reason for medication: _____

Dosage and time(s) to be taken: _____

Additional information *(if necessary)*:
_____

_____

3. Has your son/daughter had any major injuries (breaks or strains) or illness (glandular fever etc.) in the last six months that may limit full participation in any activities?

☐ Yes ☐ No

If yes, please give details of the injury/illness. Please attach any additional information if relevant.

_____

_____

_____

4. Is your son/daughter allergic to any of the following?

Prescription medication ☐ Yes ☐ No

If yes, please specify details and treatment required: _____

_____

Food ☐ Yes ☐ No

If yes, please specify details and treatment required: _____

_____

Insect bites/ stings ☐ Yes ☐ No

If yes, please specify details and treatment required: _____

_____

Other allergies ☐ Yes ☐ No

If yes, please specify details and treatment required: _____

_____

5. Has your son/ daughter been vaccinated?

☐ Yes ☐ No

If yes, please list the vaccinations they have received: _____

_____

6. Has your son/ daughter had chicken pox? ☐ Yes ☐ No

7. When was your son/ daughter's last tetanus injection? _____

8. Outline your son/ daughter's dietary requirements: _____

_____

_____

9. Please tick the box if you are happy for your son/ daughter to be administered antihistamines in the case of any allergies:

☐ Yes, I am happy for my son/ daughter to be administered antihistamines in the case of any allergies

In addition, what pain/ flu medication(s) may your son/ daughter be given if necessary? _____

_____

10. To the best of your knowledge, has your son/ daughter been in contact with any contagious/ infectious diseases in the last four weeks?

☐ Yes ☐ No

If yes, please give brief details: _____

_____

_____

11. Is there any information the Cultivate Staff should know to ensure the physical and emotional safety of your son/ daughter? (For example cultural practices, disability, anxiety, about heights/darkness/small spaces, pregnancy, behaviour or emotional problems).

☐ Yes ☐ No

If yes, please give brief details: _____

_____

_____

IF ANYTHING CHANGES BETWEEN COMPLETING THIS FORM AND COMMENCEMENT OF THE PROGRAMME, IT IS ESSENTIAL YOU LET US KNOW.

I certify I am the legal Parent/ Guardian of (Name of Student): _____

Where it is impractical to contact me, I authorise the Cultivate Staff of the programme to consent to my son/ daughter receiving such medical or surgical treatment as may be deemed necessary.

PLEAESE TICK:

☐ I agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened and handed to the designated adult with instructions on its administration.

☐ I will inform the Cultivate Discipleship Programme Staff as soon as possible of any changes in the medical or other circumstances between now and the commencement of the programme.

☐ I agree to my son/ daughter receiving any emergency medical, dental, or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

☐ Any medical costs not covered by ACC or a community service card will be paid by me.

☐ If my son/daughter is involved in a serious disciplinary problem, including the use of illegal substances and/or alcohol, or actions that threaten the safety of others, he/she will be sent home at my expense.

SWIMMING ABILITY INFORMATION:

Is your son/ daughter able to swim 50 meters?	☐ Yes	☐ No
Is your son/ daughter able to tread water?	☐ Yes	☐ No
Is your son/ daughter able to survival float?	☐ Yes	☐ No
Is your son/ daughter confident in deep water?	☐ Yes	☐ No

Please mail application to:

Cultivate Discipleship Programme
PO Box 302 659
North Harbour, Auckland 0751
New Zealand

Or

Download, fill out, and email to:
cultivateadmin@ccbi.ac.nz