**Westall Cooking Program (Global Pantry)**

**Term 1, 2024**

**The program runs every Wednesday from 3:30-5pm starting from Feb 21st at Westall Community Hub (Fairbank Room).**

Participants will be taken through weekly cooking classes where they will learn from local chefs, develop their cooking skills, and have the opportunity to connect to their culture and community. All food and equipment are provided for, you just need to show up every week!

**If you have any questions, reach out to Jessie, Program Coordinator, 0421 331 822 |** **jtang@secl.org.au**

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| **Parent/Guardian to complete this section.**The information collected in this form is only used by SECL. No information collected here will be provided to any other party (except where required by law or in an emergency). |
| **Young person’s name** |  |
| **Gender** |  |
| **Date of Birth** |  |
| **Street Address** |  |
| **Suburb** |  |
| **Postcode** |  |
| **Phone number** |  |
| **Email address** |  |
| **Country of Birth**  |  |
| **School**  |  |
| **Please tick if required:**☐ Halal food ☐ Prayer space ☐ Vegetarian ☐ Vegan ☐ Other dietary requirements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Other cultural or religious requirements (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Emergency medical treatment**If it is not possible to talk to me, I give permission for SECL to take my child to a registered doctor or hospital to get medical help. The doctor may give the medical or surgical treatment they believe is necessary. |
| Name of emergency contact |  |
| Emergency contact phone number |  |
| Language preferred by contact person |  |
| Interpreter required by contact person | Yes/No |
| Please tell us if your child has any medical conditions (e.g. Asthma, ADHD, allergies) or other special needs? Is your child on any medication? If so, list medication, frequency, and dose. | Yes/NoIf yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medicare number:** | **Healthcare Card Number:**  |

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| **General Permissions**Does **SECL** have permission to transport you/your child to events/activities? | Yes/No |
| Are you/ your child allowed to travel to and from SECL activities on their own? | Yes/No |
| I/We hereby give my consent that photos or videos taken at the event of (me) or the children registered in this event can be used for the purpose of video – audio record, live-stream reproduction in electronic & print media (website, Instagram, Facebook, television, radio & newspapers) & in **SECL, and partner organisations publications.** | Yes/No |
| I or the undersigned parent/guardian of the above-mentioned young person agree to allow the above-named young person to participate in **SECL Youth Services and partner organisations program**. I understand that **SECL and** **partner organisations Staff** involved will take all reasonable care of my young person throughout the activities. I agree to indemnify or keep indemnified and to hold harmless **SECL and partner organisations**, its employees and/or volunteers, its officers, and servants (herein after referred to as said parties) from and against all actions, costs, claims whatsoever which the above-mentioned young person and/or I may have against them arising out of or in relation to the above-mentioned program, other than where negligence attaches to them. I authorise the said parties to administer or cause to be administered such medical and like treatment that they consider is needed for the welfare of the above-mentioned young person, provided that such a person is legally able to administer such treatment. I further agree to hold all said parties harmless for such medical treatment sought for the above-mentioned child/children and I will be totally responsible for the costs of such treatment. I declare that my children are in good health and agree to advise immediately in the event of my children contracting any ailment likely to be detrimental to the health of participants.Privacy Statement: The personal information on this form is being collected for the purposes of enrolling the participant in this **SECL and partner organisations** program and being able to contact parents/guardians or to be provided to a doctor or paramedic in case of emergency. Any evaluation reports developed will not identify individual participants. This information may be shared with other **SECL Programs**, partner organisations and funding bodies. |
| **Parent/Guardian to sign for children** **under 18** |
| Name |
| Signed (Parent/Guardian)Date: |
| How did your young person find out about this activity? School ☐ flyer ☐ Facebook ☐ website ☐ friend ☐ community worker ☐ SECL staff ☐ other ☐ |

**Young Person to sign if over 18 only.**

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return the completed consent form to any staff member at SECL. If there are any changes in the details stated on the consent form, please advise immediately.

All information collected will only be used in accordance with the SECL privacy policy.

For details of the policy please visit [www.secl.org.au](http://www.secl.org.au) or contact our office.