Support Kids in Pain (SKiP)
Corporate Office
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SKiP Pain Education Program Conditions of Participation

Support Kids in Pain is committed to providing family-centered care in a safe environment. The information and expectations below outline the conditions of participation for families enrolled in the SKiP Pain Education Program.

Payment:

Families will be asked to provide payment of a donation for each section of the program, payable before attendance. As we are a not-for-profit organization, all donations will be directed to maintaining and improving the program we deliver to the community. In addition, all donations are fully tax deductible.

If you are concerned the amount will not clear into our account in time for day 1, please email a copy of the transaction receipt and we can accept this as we wait for the funds to clear. *Please note, the payment may be waived under special circumstances. Such requests will be considered on a case-by-case basis by the SKiP Medical Director and Clinical Coordinator, and need to be submitted in writing before attending the program.*

Please look for an invoice with payment details with the application confirmation. Places in the program are not confirmed until payment is made.

Participant expectations:

◇ Due to the high demand for our multidisciplinary services and limited intake capacity, we require all sessions to be well attended.

◇ **You agree to bring your child to each program day, even if a flare-up is suspected.** The aim of the SKiP program is to teach children how to cope with the fluctuating nature of chronic pain. There is value in the support, advice and clinical observation that can be offered, even if your child can only manage to attend partially.

◇ SKiP will not tolerate profanity, disruptive behavior, or any actions that are threatening to SKiP staff members or other participants. Inappropriate or unacceptable behaviour will result in immediate removal from the group.

Patient/Parent Signature: _____ Date: _____

Signature of SKiP Team Member: _____ Date: _____

Consent Form

Parent's Information	
Parent / Legal Guardian's Name:	
Address:	
Phone:	
Email:	
Young Person's Information	
Young Person's Name:	
Date of Birth:	
Medicare Information	
Medicare Number:	
Young Person's Number on the Card:	
Expiry Date:	
Medical Summary	
Medical Conditions: *Please list all known medical conditions including food allergies and/or drug allergies*	
Medication: *Please list over-the counter and/or prescription drugs taken regularly*	

Child's Pain Journey: *Please list a timeline with key dates outlining when the pain started, what you tried, who you saw and other information you think we should know about your child's pain to date.* *Please attach an additional page if needed.*	

Privacy Statement

Support Kids in Pain (SKIP) will collect and store the information you voluntarily provide to enable treatment and to prepare statistical analyses of the programs that it is undertaking. The information will be provided to relevant staff and be provided to medical professionals where necessary. You consent to these disclosures. Any information provided by you will be stored on a database that will only be accessed by authorised personnel and is subject to privacy restrictions. This information will only be used for the purposes for which it was collected.

SKIP promotes consistent adoption of information security practices to proactively address risks and threats to patient data and has developed cyber security measures to protect against unauthorised access, use, disclosure, or breach of privacy. SKIP uses a risk-based and patient-centric approach to protect confidentiality, integrity and availability of information assets, while protecting patients, staff and the organisation from privacy threats.

Whilst SKIP takes every effort available to it to protect patient data, it cannot give a warranty that its data protection systems are immune from hacking or other unauthorised access by persons engaging in fraudulent activity and employing sophisticated techniques to breach SKIP's cyber security protection mechanisms. Accordingly, you agree that SKIP will not be held responsible by you for any unauthorised access to patient data by persons employing fraudulent cyber methods. Where any data breach occurs, SKIP undertakes to:

a) notify you of the occurrence of the breach;
b) notify you as to what information may have been accessed by unauthorised persons; and
c) take whatever steps are available to it to close down and remediate the unauthorised access and report this to regulatory authorities.

Risk Warning

I agree for my child/ward to attend at the premises at which SKIP is conducting its program and to undertake all activities and/or participate in the above program.

In the case of an emergency, I authorise the program staff, where it is impracticable to communicate with me, to arrange for my child/ward to receive such medical or surgical treatment as may be deemed necessary. I also undertake to pay or reimburse costs which may be incurred for medical attention, ambulance transport and drugs while my child/ward is enrolled with the program.

I understand that although SKIP's service providers attempt to minimise any risk of personal injury within practical boundaries, accidents do happen and all physical activities carry the risk of personal injury. I acknowledge that there is an inherent risk of personal injury in physical activities that will be undertaken in the program and I accept that risk.

Media Release

At SKiP, we aim to make the pain education journey as fun and engaging as possible, so that children can be proud of what they have learnt and accomplished during the course of the program. Occasionally, our team will record the children's accomplishments by taking photographs of an activity. The purpose of this is so that the children can be inspired by what they have achieved and to show other families and donors what our programs are like.

When using these photographs for promotional purposes, we are extremely careful to make sure that no identifying information is included. This is to protect the privacy of the child and their family.

As a not-for-profit organisation, we are reliant on funders to ensure the viability of our programs. We find that being able to *show* potential donors how we operate is almost as powerful as the outcome data we present, which is why we ask all families to carefully consider giving us their media consent.

If there is a situation which makes giving permission difficult for you, please feel free to contact us at info@skip.org.au.

Yes / No I consent to allow SKIP to use any photograph, sound and film recordings taken of my child at this program for the promotion of its services and initiatives to the media and to the general public.

Yes / No I consent to allow SKIP to collect data relating to its clinical research and treatment concerning my condition and I consent to the limited use of such data for medical publications, medical presentations and for the obtaining of grants to fund SKIPs ongoing programs provided however that confidentiality is maintained about my identity and address.

Patient/ Parent Signature:	
Date:	

SUPPORT KIDS IN PAIN

Consent to Obtain/Release Medical Information

Under the Queensland *Information Privacy Act 2009*, we require your consent to collect and share personal information about your child with other health providers. Collecting this information directly from your health providers enables our team to properly assess, diagnose and treat illnesses and be pro-active in your child's health care. To continue this quality of care, we will also undertake to notify your GP and any relevant practitioners of the outcomes of your program participation.

We may also use the information you provide in the following ways:

1. Administrative purposes.
2. Billing purposes, including compliance with Medicare requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside our organisation. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you.
4. Disclosure to other allied health and medical professionals for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your records accordingly.

Please read this information carefully and sign where indicated below.

I …… (*print name*), parent/guardian of…….. (*print child's name*), provide consent for Support Kids in Pain (SKiP) to obtain information from and/or release information to the following health professionals (add additional practitioners if necessary):

GP Name (required): _____

GP Practice: _____

Address: _____

Phone: _____ **Fax**: _____

Please specify any information you DO NOT consent to have released/obtained (eg personal history):

_____

_____

Please list other health practitioners (including specialists and allied health clinicians) below:

Name: _____

Profession: Specialist GP Allied Health Other _____

Organisation: _____

Address: _____

Phone: _____ **Fax**: _____

Please specify any information you DO NOT consent to have released/obtained (eg personal history):

_____

_____

Name: _____

Profession: Specialist GP Allied Health Other _____

Organisation: _____

Address: _____

Phone: _____ **Fax**: _____

Please specify any information you DO NOT consent to have released/obtained (eg personal history):

_____

_____

Name: _____

Profession: Specialist GP Allied Health Other _____

Organisation: _____

Address: _____

Phone: _____ **Fax**: _____

Please specify any information you DO NOT consent to have released/obtained (eg personal history):

_____

_____

I have read the information above and understand the reasons why my child's information must be collected. I am also aware that this organisation has a privacy policy on handling patient information.

I have been informed and understand how this information will be used, and that this information will not be passed on to other third parties except as outlined above.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to my child.

I understand that if this information is to be used for any other purpose other than that set out above, my further consent will be obtained.

I consent to the handling of my child's information by this organisation for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Patient/ Parent Signature:	
Date:	