**Birkebeiner Nordic Ski Club**

# 2025 Junior Development Camp

**Year 2 to 9**

**Beginners to Advanced**

# Saturday 19th and Sunday 20 July 2025

# Falls Creek Alpine Resort

2 days of Cross-country ski skills development on the best XC-trails in the country with high quality instructors and coaches. Structured lessons and fun on snow activities. For full program refer to: https://www.birkebeiner.org.au/programs/junior-camps/

Please complete application, medical and any other appropriate forms and send all documentation to:

Michelle Forrer

[secretary@birkebeiner.org.au](mailto:secretary@birkebeiner.org.au)

Po Box 192, Mount Beauty Victoria 3699

Payment is to be made via **Direct Credit** to the Clubs Bank Account. Please include your name and reference as Jnr Camp. Bank details are as follows:

* **Account Name:** Birkebeiner Nordic Ski Club Inc
* **BSB:** 633 000
* **Account #: 159796739**

**Note:** Please indicate on the Application Form that you have paid by Direct Credit and by what name.

**Contacts:**

Michelle Forrer: [secretary@birkebeiner.org.au](mailto:secretary@birkebeiner.org.au) 0417206672

Jacob Huseby, [JHuseby@snow.org.au](mailto:JHuseby@snow.org.au?subject=BNSC%20Junior%20Development%20Camp&body=) or WhatsApp +1 (360) 450 1807.

Birkebeiner Nordic Ski Club

# 2025 Junior Development Camp

**Post/email to: Michelle Forrer:** [**secretary@birkebeiner.org.au**](mailto:secretary@birkebeiner.org.au)**, Po Box 192, Mount Beauty Victoria, 3699**

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Name:

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Address:

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| Phone: |
| Email: |

Contact:

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D.O.B Year Level M/F:

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School:

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Skiing experience: Beginner. Limited experience.

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Intermediate. Ski a few times a year.

May go in some events.

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Advanced. Ski regularly.

May race.

**Parent/Guardian Consent**

I agree to my child's attendance at the 2025 Junior Development Camp.

In the event of any illness or accident, where it is impracticable to communicate with me, I authorise the organizers in charge to consent to my child receiving such medical or surgical treatment as may be deemed necessary. I accept responsibility for payment of any expenses thus incurred.

I agree to my child’s photo to be published in BNSC newsletter/Facebook site, local papers ☐Yes ☐No

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**Parent/Guardian's full name:**

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**Parent/Guardian's signature:**

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**Date:**

Birkebeiner Nordic Ski Club

# 2025 Junior Development Camp

#### Medical Information

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

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**Name:**

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**Parent's/Guardian's**

**Name:**

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**Address:**

|  |
| --- |
| Home Phone: |
| Mobile: |
| Email: |

**Emergency Contacts:**

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|  |

**Medicare No:**

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**Ambulance cover:**

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**Medical/Hospital Insurance Fund:**

**Please tick if your child is typically affected by any of the following:**

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Asthma Migraine Anxiety

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Fits Travelsickness Diabetes

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Blackouts Dizzy spells Heart condition

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Other

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Medical Information page 2 for Child’s Name:

**List Allergies to:**

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1. Drugs (e.g. Penicillin)

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1. Foods

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| --- |
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1. Other

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**Tetanus Immunization:** Year of last tetanus immunization

(Note: Tetanus immunization is normally given at 5 years of age — as Triple Antigen or CDT and at 15 years of age — as ADT)

**Tablets & Medicines:** Is your child presently taking tablets and/or medicine? YES/NO

If yes, please state name of medication, dosage etc:

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| --- | --- | --- | --- |
| **Drug** | **Dose** | **Frequency** | **Comments** |
|  |  |  |  |
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All medication must be handed to the organizers on arrival. All containers must be labeled with your child's name, the dose to be taken and when it should be taken. (These will be kept in the 1st aid centre and distributed as required). If it is necessary or appropriate for your child to carry their own medication (for example, asthma puffers and insulin for diabetes) it must be with the knowledge and approval of both organizers and yourself.

Any other relevant information.

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**Consent to Medical Attention**

Where organizers are unable to contact me, or it is otherwise impracticable to contact me, I authorize

the organizers to:

• consent to my child receiving such medical/surgical attention as my be deemed necessary by a medical practitioner

• administer such 1st aid as the organisers may judge to be reasonably necessary.

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**Signature of Parent/Guardian/Date**

Birkebeiner Nordic Ski Club

# 2025 Junior Development Camp

### Asthma Management Form

The following confidential information is required to assist in the proper management of asthma sufferers whilst at the camp.

Please complete and attach to the Parent Consent Form if appropriate.

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**Child's Name:**

*Please seek the advice of the asthmatic's doctor if necessary when completing this form.*

1. Usual maintenance medical program followed:

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2. Peak flow readings: Best Critical

(bring own peak flow meter)

3. Medication and treatment to be used during worsening asthma:

|  |
| --- |
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1. Medication and treatment to be used during crisis situations:

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| --- |
|  |

5. List any known asthma trigger factor(s):

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**Key Questions**

1. Has the person been admitted to hospital due to asthma in the past 12 months?

**Yes No** (please circle)

7. Has the person been on oral cortisone for asthma within the past 12 months?

(e.g. Prednisolone, Cortisone, Betamethasone etc)

**Yes No** (please circle)

8. Has the person suffered sudden severe asthma attacks requiring hospitalisation?

**Yes No** (please circle)

**Important Notes**

If any of the key questions 6, 7, or 8 above are answered 'yes' then the decision for the person to attend the Junior Birkie camp rests with his or her doctor. The process is as follows:

• the person's doctor or parents/guardians may contact Bronwyn Gray on 0402105237 for further information on the program and support available.

• a letter from the student's doctor, stating the doctor's decision must accompany this form when it is returned.

I declare that the information provided on this form is complete and correct.

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**Name:**

**Date:**

Birkebeiner Nordic Ski Club

# 2025 Development Camp

**Anaphylaxis Management Form**

Please complete and attach to the Parent Consent Form if appropriate.

This Plan is to be completed by the parent or nominee on the basis of information from the student’s medical practitioner provided by the parent/carer.

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Child’s name:

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Date of birth: Year level:

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School:

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Severely allergic to:

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Other health conditions:

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Medication on camp:

Parent/carer information (1) Parent/carer information (2)

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Name:

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Relationship:

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Home phone:

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Work phone:

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Mobile:

Anaphalaxis Management Form page 2 for Child’s Name:

Parent/carer contact:

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Address:

Other emergency contacts

(if parent/carer not available):

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Medical practitioner contact:

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| Name: |
| Phone: |
| Mobile |

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Emergency care to be

provided on camp:

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EpiPen® storage:

The following Anaphylaxis Management Plan has been developed with my knowledge and input and will be reviewed on

(insert date of proposed review).

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Signature of parent:

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Date: