ADM.27

ACTIVITY DETAILS



ACTIVITY CONSENT FORM FOR YOUTH MEMBERS

Please click the cursor inside the box and type or print clearly with a black pen

Event:		Date of Event: From / / am/pm							
Unit:			То	/	/	am/pr	n		
This section is to be retained by the parent or legal guardian. Please see the reverse of this form for further details.									
MEDICAL INFORMATION – This section is to be brought to the event									
Name: Date of		Birth: /	1	Unit:					
Medicare Number: Card Expiry: / Application's Reference Number: Address registered for Medicare:									
Ambulance cover: YES NC	Name o	f fund/ numbe	er:						
Private health cover: YES NC	Name o	lame of fund/ number: ()							
Emergency contact details during the event, including name, phone and mobile contact details:									
I have completed the back of this form and to the best of my knowledge this information is correct and the participant is in good health									
Signature:	(Parent or	Guardian) [Date:	/	/ 2	20			
>PERMISSION TO ATTEND – This section is to be returned by: / /20									
Event:	Name of part		o rota	11104 1		of Event:	/	/ 20	
Unit:	Membership	Number:			Expir	y Date:	/	/ 20	
I, being parent/legal guardian of (full name) hereby apply for my daughter to attend the above event. If the application is accepted, to the best of my knowledge she is fit to participate and has permission to take part in all activities except for									
I undertake that she will attend this event only if, to the best of my knowledge, she has not been in contact with any infectious diseases in the three weeks prior to the event.									
I acknowledge I have been informed that a copy of <i>GuideLines</i> (publication containing the policy, organisation and rules of Girl Guides Australia) is available for inspection at all Guide venues, that the sections related to program, camping adventurous activities and policies can be viewed on the Girl Guides Australia website www.girlguides.org.au and that have been invited to read this publication.									
I authorise the Leader-in-charge to obtain first aid, medical, ambulance, dental assistance or treatment, including any anaesthetic or blood transfusion, for my daughter in the event of any illness or accident. <i>Note</i> : All reasonable attempts to make contact with the nominated 'emergency contact' will be made. I consent to the release of the health information or this form to any person who provides medical treatment and care to the applicant whilst participating in this event.									
this form to any person who provides r I agree to pay for all expenses incurre incurred.	nedical treatm d in obtaining	ent and care t such medical	to the ap aid and	plicant v to reimb	vhilst par ourse the	ticipating in organisation	this even	t.	
this form to any person who provides r I agree to pay for all expenses incurre	nedical treatm d in obtaining and to the be	ent and care t such medical	to the ap aid and	plicant v to reimb	vhilst par ourse the	ticipating in organisation	this even	t.	

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EVENT DETAILS	S – This section is to be reta	ined by the parei	nt or legal guardian					
The event will be held	at:	•						
Leader-in-charge:		Total cost of event:						
Emergency contact:		Deposit:	Due: / / 20					
Phone: ()		Balance:	Due: / / 20					
Activities:			Travel Arrangements:					
:								
×								
HEALTH FORM	– PART B – This section is	to be brought to t	he event					
This form is to help the	e first aider in caring for the health of th	ne participant. The conte	nts will remain confidential.					
Is the participant takin	g ANY medication at present?	YES NO						
If YES, please attach t	the details and management plan for a	ny condition (such as as	sthma, epilepsy, etc.)					
	oe in original packaging with original pl dication and dosage. The first aider v ol.							
Any further information	n the first aider should know:							
Does your daughter w	ear contact lenses?	YES NO						
Date of participant's la	st tetanus immunisation: /	/						
Paracetamol will not b	e administered unless provided to the	First Aider in its original	packaging and is clearly labelled					
★ HEALTH FORM								
Does the participant	Give details of any known allergies s	uch as food, insect bites	or medication:					
suffer for any of the following:								
Asthma	Does she have any disability or chronic illness or need any special health care? YES NO							
Bedwetting Diabetes	If YES, please attach details and a management plan if applicable.							
Epilepsy	Does she know about menstruation? YES NO							
Sleep Walking Fainting	Give any details of any special food requirements for medical, religious or other reasons:							
Hay Fever								
Severe Allergies	se Bleeds vere Allergies If swimming or boating is listed as an activity, please indicate her ability: WEAK AVERAC STRONG							
Parents Name:			Phone (BH):					
Address:			Phone (AH):					
State:	Posto	ode:	Mobile					

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