



CONSENT TO ATTEND A NONE OVERNIGHT ACTIVITY OR EVENT.

PLEASE PRINT ALL DETAILS

Activity/Event

Scout Group Section:

ACTIVITY/EVENT DETAILS

Minimum Maximum Please Return this Form **NO LATER THAN**

If the minimum number of participants have not returned this A3 by the 'form return date' the event will not go ahead.

Date

Location

Meet at at am/pm

Pick up from at am/pm

Cost \$ Leader Contact No of Venue

ACCEPTANCE BY LEADER (Leader to complete on return of form)

Payment Included: Signed

Top section to be returned to Applicant – Bottom section to be retained by Leader.

Activity: Amount Paid:

APPLICANTS PERSONAL DETAILS

Name Membership No:

Home Address

Date of Birth Applicants Level of Swimming

EMERGENCY CONTACT during Activity/Event

Name Relationship to Applicant

Address

Phone Home Work Mobile

ACCEPTANCE

I give permission for the applicant to attend the Overnight Activity (details as above) and for the Leader in charge to seek medical attention for the applicant should the need arise. I further agree that I have completed the health statement (overleaf) and attached any further information that could affect the welfare of the applicant.

I give permission for the Leader in charge to administer the following medications without seeking my further permission:

Paracetamol	YES / NO	Nurofen	YES / NO	Panadol	YES / NO	Claratyne	YES / NO
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
Signature of Applicant (if over 18 years)		Signature of Parent/Guardian (if applicant under 18 years)			Date		



OTHER INFORMATION

HEALTH STATEMENT

MEDICATION: Please provide details of medication the applicant will be taking during the Activity

Type: Dosage:
Frequency of Dose:

DIETARY REQUIREMENTS: Please provide details of any dietary requirements

ALLERGIES/AILMENTS/DISABILITIES: Please provide details of any allergies, ailments or disabilities:

IMMUNISATION

Has Applicant been immunised against Tetanus in the past 5 years?

If Not: Can the applicant be given a Tetanus injection should the need arise?

Date of Immunisation:

Medicare No:

Ambulance Fund No:

Health Fund:

Health Fund No: