PLEASE RETURN COMPLETED FORM TO THE ACTIVITY COORDINATOR

ACTIVITY NOTIFICATION FORM
PART I - ACTIVITY PARTICIPATION AND MEDICAL FORM
(This page is to be completed and returned for All Participants)

*This is a PDF form which **must be used with Adobe Reader**. Download the form and save it to your computer. Ensure that Adobe Reader is installed on your device **and is being used to Open/Edit/Save the form**.*

ACTIVITY DETAILS - (FOR FULL DETAILS PLEASE SEE PAGE 2)

ACTIVITY: **Flip Out** ACTIVITY NO:

GROUP/FORMATION: **1st Bomaderry Joey Scouts**

LOCATION: **Flip Out, Tom Thumb Avenue, South Nowra**

START TIME (24hr): **5:00pm** DATE: **Wednesday, 27 Mar 2019** FROM: **Flip Out, Tom Thumb Ave, South No**

FINISH TIME (24hr): **6:00pm** DATE: **Wednesday, 27 Mar 2019** TO: **Flip Out, Tom Thumb Ave, South No**

Name of Activity Coordinator: **Catherine Bath** Phone: **0419463 800**

Cost: **$14.00** Payable to: **Flip Out** Closing Date: **Wednesday, 27 Mar 2019**

Method of transport to and from the activity: **Parents Own**

PARTICIPANT DETAILS - TO BE COMPLETED BY ALL PARTICIPANTS OR PARENT/GUARDIAN IF UNDER 18 YEARS

GROUP/FORMATION: MEMBERSHIP NO.

SECTION: ☐ Joey Scout ☐ Cub Scout ☐ Scout ☐ Venturer ☐ Rover ☐ Leader ☐ Helper / Instructor / Non Member

SURNAME: GIVEN NAMES:

ADDRESS:

TOWN/CITY: STATE: POST CODE:

TELEPHONE: MOBILE: E-MAIL:

DATE OF BIRTH: GENDER: ☐ Male ☐ Female RELIGION/FAITH: (Optional)

ATTENDANCE:	☐ ALL	☐ Friday	☐ Saturday	☐ Sunday	☐ Days Only
		☐ Friday Night	☐ Saturday Night	☐ Sunday Night	☐ Other

In case of Emergency contact: Phone:

Address: Suburb: Mobile:

If the participant suffers from any condition, ailment, allergy or disability that could affect their participation in the activity, it should be disclosed so provision can be made for their welfare and participation. Further details can be given on the back of this form. Please attach any Medical Plans that apply.

Does the participant have any conditions or disabilities that could affect their participation?
☐ **Yes** **Details:**

Does the participant have any known allergies, including drugs or food allergies? (i.e. Penicillin, Egg, Peanut Products, Bee Stings, Hay Fever, other drug or food allergies):
☐ **Yes** **Details:**

Has the participant any special food requirements? (for Medical, Religious)
☐ **Yes** **Details:**

Medicare Number:

Date of last Tetanus Injection: **or** ☐ **unknown**

Does the participant suffer from any of the following?

Epilepsy:	☐ **Yes**	**Level:**	☐ **Mild**	☐ **Severe**
Diabetes:	☐ **Yes**	**Level:**	☐ **Mild**	☐ **Severe**
Asthma:	☐ **Yes**	**Level:**	☐ **Mild**	☐ **Severe**

Will the participant have any medication at the activity?
(i.e. Penicillin, Insulin or other Drugs administered by Injection, Tablet, Capsules, EpiPens or other).
☐ **Yes** Name of Drug:
Dosage: How Often:
Administered by: ☐ self or ☐ whom:

PARENT CONSENT - TO BE COMPLETED BY PARENT/GUARDIAN FOR PARTICIPANTS UNDER 18 YEARS

Can the participant Swim 50 meters? ☐ Yes

I consent to my childs participation in the following which may be a part of this Activity.

☐ Swimming ☐ Water/Boating Activities ☐ Rock Related Activities ☐ Abseiling ☐ Flying Fox ☐ Flying

MEDICAL AUTHORITY - TO BE COMPLETED BY ALL PARTICIPANTS OR PARENT/GUARDIAN IF UNDER 18 YEARS

I/We acknowledge that this activity will involve inherent and obvious risks. I/We authorise any officer, member, servant or agent of The Scout Association of Australia, New South Wales Branch, in the event of any accident or illness to obtain such urgent medical assistance or treatment for the above named participant, including the administration of any anaesthetic or blood transfusion as he or she may consider expedient and for this purpose to engage any first aiders, ambulance officers, doctors, dentists, nursing assistance or hospital accommodation and in this event I agree to pay the said Association on demand all such doctors', dentists', nurses', ambulance and hospital fees (other than fees and expenses recoverable by the said Association under any policy of insurance).

If you have any questions please contact: Catherine Bath Phone 0419463 800

Participant:			
Parent/Guardian (If Participant Under 18 Years)	Signature	Print Name	Date

Scouts Australia NSW
Level 1, Quad 3
102 Bennelong Parkway
Sydney Olympic Park NSW 2127

PO Box 125
Lidcombe NSW 1825

Ph: (02) 9735-9000 Fax: (02) 9735-9001
Email: info@nsw.scouts.com.au

ACTIVITY NOTIFICATION FORM
PART II - PARTICIPANTS & PARENTS ADVICE
(This page is to be kept by participants)

ACTIVITY DETAILS

ACTIVITY: **Flip Out** ACTIVITY NO:

GROUP/FORMATION: **1st Bomaderry Joey Scouts**

LOCATION: **Flip Out, Tom Thumb Avenue, South Nowra**

START TIME (24hr): **5:00pm** DATE: **Wednesday, 27 Mar 2019** FROM **Flip Out, Tom Thumb Ave, South No**

FINISH TIME (24hr): **6:00pm** DATE: **Wednesday, 27 Mar 2019** TO **Flip Out, Tom Thumb Ave, South No**

Name of Activity Coordinator: **Catherine Bath** Phone: **0419463 800**

Cost: **$14.00** Payable to: **Flip Out** Closing Date: **Wednesday, 27 Mar 2019**

Method of transport to and from activity: **Parents Own**

The activity	☑ will	☐ will not	be under direct adult supervision.
The activity	☑ will	☐ will not	involve both male and female youth members.
Both male and female Leaders	☑ will	☐ will not	be present

EMERGENCY CONTACT

If you feel that the participant is overdue in returning from the activity you should contact the nominated emergency contact.

Name: **Andrew Bath** Home Phone: **4422 6527** Mobile: **0411 053 106**

ADDITIONAL DETAILS

Provide details about the activity. Can include gear lists, map references etc.

Meet at Flip Out

Full uniform (remove scarf before jumping)

Bring Socks & drink bottle