



**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: ALBURY GANG SHOW REHEARSALS ACTIVITY NO: AGS2024
GROUP/FORMATION: ALBURY GANG SHOW
LOCATION: Albury Gang Show HQ, 2nd Albury Scout Hall, North Street, Albury
START TIME (24hr): _____ DATE: Tuesday, 13th Feb 2024 FROM: _____
FINISH TIME (24hr): _____ DATE: Saturday, 10th Aug 2024 TO: _____
Name of Activity Coordinator: Anne Moffat Phone: 0416 715 150
Cost: _____ Payable to: _____ Closing Date: _____
Method of transport to and from the activity: own means

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

GROUP/FORMATION: _____ MEMBERSHIP NO.

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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:	<input type="checkbox"/> ALL	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday	<input type="checkbox"/> Sunday	<input type="checkbox"/> Days Only
	<input type="checkbox"/> Friday Night	<input type="checkbox"/> Saturday Night	<input type="checkbox"/> Sunday Night	<input type="checkbox"/> 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.

<p>Does the participant have any conditions or disabilities that could affect their participation? <input type="checkbox"/> Yes Details: _____</p> <p>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): <input type="checkbox"/> Yes Details: _____</p> <p>Has the participant any special food requirements? (for Medical, Religious) <input type="checkbox"/> Yes Details: _____</p> <p>Date of last Tetanus Injection: _____ or <input type="checkbox"/> unknown</p>	<p>Does the participant suffer from any of the following?</p> <p>Epilepsy: <input type="checkbox"/> Yes Level: <input type="checkbox"/> Mild <input type="checkbox"/> Severe</p> <p>Diabetes: <input type="checkbox"/> Yes Level: <input type="checkbox"/> Mild <input type="checkbox"/> Severe</p> <p>Asthma: <input type="checkbox"/> Yes Level: <input type="checkbox"/> Mild <input type="checkbox"/> Severe</p> <p>Will the participant have any medication at the activity? (i.e. Penicillin, Insulin or other Drugs administered by Injection, Tablet, Capsules, EpiPens or other). <input type="checkbox"/> Yes Name of Drug: _____ Dosage: _____ How Often: _____ Administered by: <input type="checkbox"/> self or <input type="checkbox"/> whom: _____</p>
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PARENT CONSENT - TO BE COMPLETED BY PARENT/GUARDIAN FOR PARTICIPANTS UNDER 18 YEARS

Can the participant Swim 50 meters? ☐ Yes
I consent to my child's 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: Anne Moffat Phone 0416 715 150

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