



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)

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

ACTIVITY: _____ ACTIVITY NO: _____
GROUP/FORMATION: _____
LOCATION: _____
START TIME (24hr): _____ DATE: _____ FROM: _____
FINISH TIME (24hr): _____ DATE: _____ TO: _____
Name of Activity Coordinator: _____ Phone: _____
Cost: _____ Payable to: _____ Closing Date: _____
Method of transport to and from the activity: _____

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 chronic or recurrent ailment, allergy or physical defect, it should be disclosed in order that provision can be made for their welfare. Further details can be given on reverse side. Please attach any Medical Plans if they apply.

Does the participant have any physical disabilities? [] 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 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: _____ Phone _____

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



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 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: _____ ACTIVITY NO: _____

GROUP/FORMATION: _____

LOCATION: _____

START TIME (24hr): _____ DATE: _____ FROM _____

FINISH TIME (24hr): _____ DATE: _____ TO _____

Name of Activity Coordinator: _____ Phone: _____

Cost: _____ Payable to: _____ Closing Date: _____

Method of transport to and from activity: _____

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: _____ Home Phone: _____ Mobile: _____

ADDITIONAL DETAILS

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