FORM A1 (06/09)

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: ______
LEAVING TIME (24hr): ______ DATE: ______ FROM: ______
RETURNING 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 suffer from 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

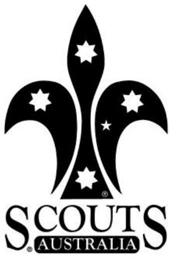
Can the participant Swim 50 metres? ☐ Yes
I consent to my childs participation in the following which may be a part of this Activity.
☐ Swimming ☐ Water/Boating Activities ☐ Rock Related Activities ☐ Abseiling ☐ Flying Fox ☐ Flying

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: ______ Phone ______

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



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

ACTIVITY DETAILS

ACTIVITY: ______________________ ACTIVITY NO: __________

GROUP/FORMATION: ______________________

LOCATION: ______________________

LEAVING TIME (24hr): ________ DATE: ________ FROM ________

RETURNING 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.