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: **AGS2025**

GROUP/FORMATION: **AKBURY GANG SHOW**

LOCATION: **Albury Gang Show HQ, 2nd Albury Scout hall, North Street, Albury**

START TIME (24hr): _____ DATE: **Tuesday, 11th Feb 2025** FROM: _____

FINISH TIME (24hr): _____ DATE: **Saturday 16th Aug 2025** TO: _____

Name of Activity Coordinator: **Anne Moffat** Phone: **0416715150**

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. _____

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:** _____

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: AGS Cast Phone Phone 0416715150

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