Office Use
Receipt No
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Scouts Australia – NSW
Hunter & Coastal Region

APPLICATION TO ATTEND CUB-O-REE 2008

1. Draw all cheques/money orders payable to "Scout Association – NSW Branch" ONLY.
2. **Parents – Return this form with money to your local Cub Scout Leader.**
3. Groups to send forms and group cheque to PO Box 854 The Junction 2291
4. Fax/email copies are not accepted. Original signatures are required.

Location: Mt Penang Gardens, Kariong	Date/s: 26 – 28 Sept	PED: Yes/No
Attending this Activity as: (please circle) Cub/Scout/Leader/Adult Helper/other		
Second Payment : Cub Scouts $45 Leaders/Adults/Scouts $20 Total fees due: Cub Scouts $75 Leaders/Adults/Scouts etc $40		First Payment: $30 Leaders/Adults $20 Transport costs may be extra

Membership No. | | | | | | |

Surname:		Given Names (Both):	
Address:			
Postcode:	Telephone ( )	Sex: Male/Female	Date of Birth:
Group:	Section:	Email Address:	
If attending a Water Course what type of Craft: Canadian/ Kayak/ Sailboat			

Contact Person:	Relationship	
The following information is only required if it is NOT the same as above.		
Address:		
Postcode:	Telephone: ( )	Mobile: ( )

PLEASE COMPLETE HEALTH STATEMENT ON REVERSE

APPLICANTS SIGNATURE: ____
(Applicants signature not required for those under 18 years)

PARENTS / GUARDIANS SIGNATURE: _____________________________ **DATE:**

SECTION LEADER'S SIGNATURE: ________________________________ **DATE:**

Medical Authority.

I agree that, if selected, my son/daughter shall abide by the regulations governing the Activity concerning his/her conduct and shall carry out the directions of the Camp Chief or such Deputy as he/she may appoint.

I authorise any officer, member or servant 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 applicant, 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).

Medical Statement

Name: ____Group:
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Medicare No.:_______________________________________ Are you a member of a Private Health Fund? Yes/No

Fund Name: ______________________ ___________________ Membership

No.:____

Ambulance Cover Yes/No

Family Doctor: ____ Contact Number: _____________________________________

Immunisation: It is recommended that you are fully immunised as per the National Health and Medical Research Council Schedule. Please provide the date of your last Tetanus immunisation: ___________________________

Do you wear a medical alert necklace/bracelet? Yes/No Necklace/ Bracelet If yes please give details

Medical alert details:____

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Do you take medication regularly? Yes/No If yes, please give details below

Drug	*Dose*	*Method of Administration*

Do you have any allergies? Yes/No If yes please give details below
(E.g. Drugs, Plaster, Toiletries, Food, Insects)

Allergies	*Type of Reaction*	*Treatment*

Do you use any medical aids? Yes/No If yes please give details below

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Do you have any special dietary requirements? Yes/No If yes please give details below

(For Medical or Religious reasons **only**)

	Diabetic		No Gluten		Vegetarian
	No Dairy / No Lactose		Other – Please Specify		Religious/Belief

Medical Conditions

If you suffer from any of the following ailment or conditions, please indicate by ticking the appropriate place, so that provision can be made for your welfare. Please also give details regarding any affirmative answers in the space provided below.

	Angina		Diabetes		Nose Bleed
	Asthma		Epilepsy		Skin Condition
	Blackouts		Hearing Disorders		Sleep Walks
	Bleeding Disorders		Hearth Trouble		Ulcers
	Blood Pressure		Hives		Visual Impairment
	Bronchitis		Migraine		Other (inc Physical Disability)

Details of medical condition and support required:

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SHOULD YOUR MEDICAL CONDITION CHANGE FROM THE INFORMATION PROVIDED ABOVE IN ANY WAY, PRIOR TO ATTENDING THE EVENT, IT IS YOUR OBLIGATION TO ADVISE THE COURSE LEADER AND/OR CAMP DIRECTOR!

PARENTS / GUARDIANS SIGNATURE: ____ **DATE:**

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