

# Scouts Australia – NSW Hunter & Coastal Region

**Office Use**

Receipt No

## *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		First Payment: \$30 Leaders/Adults \$20
Total fees due: Cub Scouts \$75 Leaders/Adults/Scouts etc \$40		Transport costs may be extra

Membership No. 

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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: \_\_\_\_\_

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: \_\_\_\_\_

**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

**Do you have any special dietary requirements?** Yes/No      If yes please give details below  
(For Medical or Religious reasons **only**)

<input type="checkbox"/> Diabetic	<input type="checkbox"/> No Gluten	<input type="checkbox"/> Vegetarian
<input type="checkbox"/> No Dairy / No Lactose	<input type="checkbox"/> Other – Please Specify	<input type="checkbox"/> 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.

<input type="checkbox"/> Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nose Bleed
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Hearing Disorders	<input type="checkbox"/> Sleep Walks
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Hearth Trouble	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Hives	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Migraine	<input type="checkbox"/> Other (inc Physical Disability)

Details of medical condition and support required:

\_\_\_\_\_

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:** \_\_\_\_\_

