

Scouts Australia – NSW Hunter & Coastal Region

APPLICATION FOR ACTIVITY LEADER/INSTRUCTOR

1. All information must be filled in or it will be refused. This form is to be forwarded to the Regional Commissioner (Activities) c/- PO Box 854 The Junction 2291.
2. Fax copies will be accepted (Fax: 4929-1753)
3. New applications require 1 Instructors & 1 Assessor's signature
4. Renewal applications require 1 Assessor's signature.

This is for a Region Appointment (NOT Branch &/or National) Please tick one New Renewal

Membership No.

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Title:		Surname:			
Given Names (both):			Preferred Name:		
Address:					
				Postcode:	
Telephone Number:	Home:		Business:		Mobile:
Date of Birth:		E-mail:			
Appointment:			Formation:		
First Aid:	Type:		Number:		Expiry Date:

Appointment Applied For:

Particulars to support this Application:

Date:	Particulars:

Applicant's Signature: _____ Date: _____

Instructors Name: _____ Certificate No. _____

Instructors Signature: _____ Date: _____

Assessors Name: _____ Certificate No. _____

Assessors Signature: _____ Date: _____

Applicant's Name: _____

Health Statement

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.

<p>A: Does the applicant suffer from any physical disabilities</p>	<p>Yes/No</p>	<p>If yes, details _____ _____</p>
<p>B: Does the applicant suffer from</p> <p>1. Diabetes Severe / Mild</p> <p>2. Asthma Severe / Mild</p> <p>3. Epilepsy Severe / Mild</p> <p>4. Heart or Blood Pressure</p>	<p>Yes/No Yes/No Yes/No Yes/No</p>	<p>Space for further explanation is required _____ _____ _____ _____</p>
<p>C: Does the applicant have any known allergies, including drugs or food allergies. (i.e. Penicillin, Egg, Bee Sting, Hay Fever, other Drug or Food allergies).</p>	<p>Yes/No</p>	<p>_____ _____ _____ _____</p>
<p>D: Will the applicant have any medication at the activity? (i.e. By Injection, Tablet Capsule, Penicillin, Insulin, other Drugs).</p>	<p>Yes/No</p>	<p>Name of Drug _____ Dosage _____ Reason _____ How often administered and by whom _____ _____</p>
<p>E: Has applicant any special food requirements (for Medical, Religious)</p>	<p>Yes/No</p>	<p>If yes, details (if insufficient room please attach letter) _____ _____ _____</p>
<p>F: Date of last Tetanus Injection</p>		
<p>G: Medicare Number</p>		
<p>H: Name of Medical Fund</p>		
<p>I: Ambulance Fund Cover</p>	<p>Yes/No</p>	