



**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: \_\_\_\_\_ ACTIVITY NO: \_\_\_\_\_  
 GROUP/FORMATION: \_\_\_\_\_  
 LOCATION: \_\_\_\_\_  
 START TIME (24hr): \_\_\_\_\_ DATE: \_\_\_\_\_ FROM: \_\_\_\_\_  
 FINISH 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:	<input type="checkbox"/> ALL	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday	<input type="checkbox"/> Sunday	<input type="checkbox"/> Days Only
		<input type="checkbox"/> Friday Night	<input type="checkbox"/> Saturday Night	<input type="checkbox"/> Sunday Night	<input type="checkbox"/> 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? <input type="checkbox"/> Yes Details: _____	Does the participant suffer from any of the following? Epilepsy: <input type="checkbox"/> Yes Level: <input type="checkbox"/> Mild <input type="checkbox"/> Severe Diabetes: <input type="checkbox"/> Yes Level: <input type="checkbox"/> Mild <input type="checkbox"/> Severe Asthma: <input type="checkbox"/> Yes Level: <input type="checkbox"/> Mild <input type="checkbox"/> Severe
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): <input type="checkbox"/> Yes Details: _____	Will the participant have any medication at the activity? (i.e. Penicillin, Insulin or other Drugs administered by Injection, Tablet, Capsules, EpiPens or other). <input type="checkbox"/> Yes Name of Drug: _____ Dosage: _____ How Often: _____ Administered by: <input type="checkbox"/> self or <input type="checkbox"/> whom: _____
Has the participant any special food requirements? (for Medical, Religious) <input type="checkbox"/> Yes Details: _____	
Medicare Number: _____ Date of last Tetanus Injection: _____ or <input type="checkbox"/> unknown	

**PARENT CONSENT - TO BE COMPLETED BY PARENT/GUARDIAN FOR PARTICIPANTS UNDER 18 YEARS**

Can the participant Swim 50 meters?  Yes  
 I consent to my child's 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 \_\_\_\_\_  
 Participant: \_\_\_\_\_  
 Parent/Guardian (If Participant Under 18 Years) \_\_\_\_\_  
 Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_



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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: \_\_\_\_\_

START TIME (24hr): \_\_\_\_\_ DATE: \_\_\_\_\_ FROM \_\_\_\_\_

FINISH 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.