



Complete in **BLOCK CAPITALS** **Membership Fee Is 50p Per Person per year

UNDER AGE 18 Annual Membership/Consent Form**

Membership is only open to residents of Woodvale and Ainsdale area.

Use only ONE FORM PER PERSON

***DELETE AS APPROPRIATE**

Membership Paid: Y / N Date Pd: ___/___/___ Membership No. ___ Staff Signature: _____

Before returning this form please **ANSWER & COMPLETE ALL QUESTIONS FULLY**

ACTIVITY/COURSE: _____

Have you previously participated in any other Activities/Courses organised by the Association? ***YES / NO**

Full Name: _____ ***Male / Female** D.O.B.: _____ Age: _____

Address: _____

_____ Postcode: _____ Ethnicity: _____

Home Tel No: _____ Mobile Tel No: _____

Email: _____

IN AN EMERGENCY PLEASE CONTACT: Name: _____ Relationship _____

Address: _____

Home Tel No: _____ Mobile Tel No _____

***YES** I will allow my child to make their own way home after the activity has finished

***NO** I will make arrangements to collect my child after the activity has finished

If under 18 years of age, Parent/Carer to complete the following:

***I** consent to my child taking part in the above Activity/Course

***I** give my permission for images of my Child/Ward to be used in publications relating to this event

SIGNED: _____ ***Parent/Guardian/Carer** **DATE:** _____

HEALTH FORM: Has your Child/Ward, to your knowledge been in contact with any infectious disease/s in the last 3 weeks? ***YES / NO** If **YES** give details: _____

Does your Child/Ward suffer from any Health Issue/Allergy/Disability we should be made aware of?

***YES / NO** If **YES** please give details here: _____

If under 18 years of age is your Child/Ward receiving any medical treatment at present? ***YES / NO** If **YES** and relevant to Activity/Course please give details here: _____

Date of last TETANUS injection, if known: _____ Can your child SWIM? ***YES / NO**

IT IS IMPORTANT THAT YOU FULLY COMPLETE THIS SECTION BELOW

Name of Own Doctor: _____ Address of Own Doctor: _____

_____ Own Doctor's Telephone No: _____

PERMISSION TO CONSENT TO MEDICAL TREATMENT

In the event of medical attention being required, I authorise the Activity/Project Leader to call a doctor or ambulance to administer any relevant medical assistance or medication to my child.

SIGNED: _____ ***Parent/Carer** **DATE:** _____

***Please note: We must have an original signature, therefore copied or emailed consent forms are not acceptable.**

Times between certain sessions are not supervised by staff.
The Association is **NOT** responsible for your child during this time. Please make appropriate provision for this time.