**{Organisation Name}**

**Membership Form**

Please note that the information on this form is for the use of the youth workers at **{organisation name}** and is not made available to any other individuals or groups. This means that we will not disclose your e-mail address, mobile number or any other details to another individual without your permission.

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| --- | --- | --- |
| **Personal Details** | | |
| **Name:** | | |
| **Address:** |  | Email Address: |
| **Telephone Numbers:** | Home: | Mobile: |
| **Date of Birth:** |  | |
| **Name of Parent/Guardian:** |  | |
| **Address:** |  | Email Address: |
| **Telephone Numbers:** | Home: | Mobile: |
| **Doctor:** | Name:  Surgery: | Address:  Telephone No.: |
| **School:** | Name: | Address:  Telephone No.: |

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| **Medical Information – for completion by Parent/Guardian** |
| Does your son/daughter suffer from any conditions requiring medical treatment, including medication? **Yes/No** (delete as applicable)  If **Yes** please specify (including treatment): |
| Does your son/daughter suffer from any other medical conditions? **Yes/No** (delete as applicable)  If **Yes** please specify: |
| To the best of your knowledge, has your son/daughter been in contact with any contagious or Infectious diseases or suffered from anything in the last four weeks that may be or become contagious or infectious? **Yes/No** (delete as applicable)  If **Yes** please specify: |
| **Medical Information (continued)** |
| Does your son/daughter suffer from any allergies? (e.g. plasters, aspirin, antiseptics, nuts etc.) **Yes/No** (delete as applicable)  If **Yes** please specify: |
| Has your son/daughter received a tetanus injection in the last five years? **Yes/No** (delete as applicable)  If **Yes** please supply the date: |
| Does your son/daughter have any special dietary requirements? your son/daughter suffer from any allergies? (e.g. plasters, aspirin, antiseptics, nuts etc.) **Yes/No** (delete as applicable)  If **Yes** please specify: |

|  |  |  |
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| **Emergency Contacts** | | |
| **Name of first emergency contact:** | | |
| **Address:** |  | Email Address: |
| **Telephone Numbers:** | Home: | Mobile: |
| **Name of second emergency contact:** | | |
| **Address:** |  | Email Address: |
| **Telephone Numbers:** | Home: | Mobile: |

**Declaration**

I am the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* To the best of my knowledge my son/daughter is not suffering from any medical condition that makes them unfit to attend the Club.
* I give the Youth Worker in charge permission to give first aid to my son/daughter if necessary
* I give the Youth Worker in charge permission to take my son/daughter to a doctor if necessary, if I cannot be contacted.
* I give the Youth Worker in charge permission to take my son/daughter to the hospital for emergency treatment if I cannot be contacted.
* I agree to my son/daughter receiving medical treatment, including anaesthetic, as considered necessary by the medical authorities present.

**(Please delete any of the above as applicable)**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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