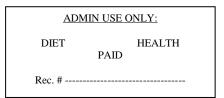
## Rotary Youth Program of Enrichment

District 9640







## Application Form Camp Bornhoffen 9am, Friday 17<sup>th</sup> May- 1pm, Sunday 19<sup>th</sup> May 2019

(QLD time)

Please note: If you ha	ive pre	viously	attende	ed a RYP	EN camp	you cannot app	ly a sec	cond t	ime. Sorry!
SURNAME:				FIRST NAME:					
PREFERRED NAME:					GEND	ER: (Please Circl	le)	M	F
RESIDENTIAL ADDRESS:									
						POSTC	ODE:_		
POSTAL ADDRESS:									
						POSTC	ODE: _		
TELEPHONE:					EMAIL	·			
MOBILE:	DAT	E OF BI	RTH: _			_AGE (as at 2 <sup>nd</sup> l	May 20	19): _	
WHAT SCHOOL DO YOU AT	TEND	?					WHAT	GRAI	DE?
T-SHIRT SIZE (please circle)	SM	MD	LG	XLG	XXLG				
I agree that I will NOT smok such as mobile phones, lap on arrival or leave it at hom also confirm that I have not	tops a e. I ag	nd iPod ree to a	s etc. v bide by	vhile att	ending F np rules	RYPEN. I will suit and all direction	rrende	r my	mobile phone
Awardee Signature:						Date:			
SPONSORING CLUB DETAILS – to									
CLUB NAME:									
ADDRESS:									
CONTACT PERSON:						_TELEPHONE: _			
EMAIL:									

Chair:

Kathy Smith Ph: 0417826547

Email: kathy@chicksconqueringcancer.org

SIGNATURI	E:		DATE:
Emergency C	ontact Details – Applicant to	complete	
		treated with strict confidentiality. I vailable to person/s handling the tre	
Parent or Gu	ardian		
Dr / Mr / Mrs	/ Ms		
(Surname)			(First Name)
			Post Code:
PHONE	Home:	Work:	Mobile:
Next Contact			
Dr / Mr / Mrs			
ADDRESS:	(Surname)		(First Name)
			Post Code:
PHONE	home:	work:	mobile:
Your Regular	· Practitioner		
DOCTOR:	<u></u>	LOC	ATION:
PHONE pract	tice:	afte	er hours:
Please list a	ny medications you take, w	hen you take them and the do	se:
	ring adequate supply of any r ens, inhalers, nebulisers)	nedications you require and equ	ipment needed to administer them
	mber:		
Medicare Nur			
	red by a private health care f	und? Y / N Details:	
Are you cove	red by a private health care for red by an ambulance plan? Y		

Chair:
Kathy Smith
Ph: 0417826547
Email: kathy@chicksconqueringcancer.org

NB: Favourite music/group/song\_

Medical Information Please list any medical of	conditions that you have.
ASTHMA: Treatment	If you are hyperconsitive allergie or have had adverse
Have you been hospitalised due to asthma? Y/N If so, when and duration?	If you are hypersensitive, allergic or have had adverse reactions to food, medications, tetanus antitoxins or serums, please indicate the agent, the type of reaction and the treatment or medication.  MEDICATION:
	Reaction
Have you had a <b>Tetanus</b> injection in the last 5 years? Y/N If so, when and where?	Treatment
Are you a <b>diabetic</b> ? Y / N If so, what medication do you require?	FOOD: Reaction
Do you suffer from <b>epilepsy</b> ? Y / N If so, what medication do you require?	Treatment
Have you been exposed to any <b>communicable diseases</b> within the last 6 months? Y/N If so, please explain and indicate what medication	INSECT BITE / STING: Reaction
you require  Do you take <b>recreational drugs</b> , or are you addicted to any drugs? Y / N	Treatment
If so, please explain	OTHER: Reaction
Do you have any <b>medical</b> , <b>physical or mental condition</b> which would not allow you to participate 100% during this camp?  Y/N	Treatment
If so, please explain	
Please list any other health, medical or personal details, no eg. pending operations	ot covered above, you want us to know about:

Please provide any health information that may be useful in the event of an illness or injury.

<u>Chair:</u>
<u>Kathy Smith</u>
<u>Ph: 0417826547</u>

Email: kathy@chicksconqueringcancer.org

Please specify any	dietary requirements you have: (eg. gluten free, sugar free, vegetarian)
Parent / Guardi	an Acceptance/Authorisation:
partners who live of each participa	minar is conducted and supervised by Rotarians, alumni and Friends of Rotary and their in with the participants. Strict rules will be enforced to ensure the safety and well-being ant. Accident insurance has been taken out for the duration of the seminar. We need you a medical assistance should an emergency occur.
Please sign belo	w to give that approval.
l,	give the RYPEN Chairperson permission to arrange ambulance
	lical attention for my son/daughter/ward,, if essary. I expect to be notified as soon as possible.
I agree to the ab	ove medical information provided being made available to medical practitioners if the varrant.
	N committee, permission to use appropriate photos of my child/children of promoting Rotary Youth programs, and for the use on social media.
	Date:
(Parent / Guardian)	
	note that this application form requires the signature of the applicant, Rotary ub representative and parent / guardian before being accepted as complete.
	se forward completed application form by email by 5th MAY 2019 to Kathy Smith: kathy@chicksconqueringcancer.org COST: \$295 Payment by Direct Bank Deposit to: nternational District 9640 Limited. BSB: 084 462 Account No: 796395692 You can do this via the Internet or at Your Local Bank
Send Co	NB: Please indicate that the deposit is for RYPEN and by of Receipt of Payment by email to Kathy Smith (above)
Not	e here with a cross (X) that payment has been made

Chair:
Kathy Smith
Ph: 0417826547
Email: kathy@chicksconqueringcancer.org