Rotary Youth Program of Enrichment

District 9640

ADMIN USE ONLY:
DIET HEALTH PAID
Rec. # ----------

Application Form
Camp Bornhoffen 9am, Friday 17th May– 1pm, Sunday 19th May 2019

(QLD time)

Please note: If you have previously attended a RYPEN camp you cannot apply a second time. Sorry!

SURNAME:_____ FIRST NAME: _____

PREFERRED NAME: _____ GENDER: (Please Circle) **M** **F**

RESIDENTIAL ADDRESS: _____

_____POSTCODE:_____

POSTAL ADDRESS: _____

_____POSTCODE: _____

TELEPHONE: _____ EMAIL_____

MOBILE:_____DATE OF BIRTH: _____AGE (as at 2nd May 2019): _____

WHAT SCHOOL DO YOU ATTEND? _____ WHAT GRADE? _____

T-SHIRT SIZE (please circle) SM MD LG XLG XXLG

I agree that I will NOT smoke, use non-prescription drugs, drink alcohol or use personal electronic devices such as mobile phones, laptops and iPods etc. while attending RYPEN. I will surrender my mobile phone on arrival or leave it at home. I agree to abide by the camp rules and all directions from the camp leaders. I also confirm that I have not attended a RYPEN camp previously.

Awardee Signature: _____ Date: _____

……..

SPONSORING CLUB DETAILS – to be completed by Rotary Club

CLUB NAME: _____

ADDRESS: _____

CONTACT PERSON: _____TELEPHONE: _____

EMAIL: _____

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

SIGNATURE: _____ DATE: _____

Emergency Contact Details – Applicant to complete

The information requested on this form will be treated with strict confidentiality. It is to assist in the preparation of the camp and in case of emergency be made available to person/s handling the treatment.

Parent or Guardian

Dr / Mr / Mrs / Ms _____
(Surname) *(First Name)*

ADDRESS: _____

_____ Post Code: _____

PHONE Home: _____ Work: _____ Mobile: _____

Next Contact

Dr / Mr / Mrs / Ms _____
(Surname) *(First Name)*

ADDRESS: _____

_____ Post Code: _____

PHONE home: _____ work: _____ mobile: _____

Your Regular Practitioner

DOCTOR: _____ LOCATION: _____

PHONE practice: _____ after hours: _____

Please list any medications you take, when you take them and the dose: _____

_____

_____

NB. Please bring adequate supply of any medications you require and equipment needed to administer them (eg. insulin pens, inhalers, nebulisers)

Medicare Number:_____

Are you covered by a private health care fund? Y / N Details:_____

Are you covered by an ambulance plan? Y / N

Any special instructions: _____

_____

NB: Favourite music/group/song_____

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

Medical Information Please list any medical conditions that you have.

_____

_____

ASTHMA:
Treatment _____

_____

Have you been hospitalised due to asthma? Y / N
If so, when and duration? _____

_____

Have you had a **Tetanus** injection in the last 5 years? Y / N
If so, when and where? _____

_____

Are you a **diabetic**? Y / N
If so, what medication do you require? _____

_____

Do you suffer from **epilepsy**? Y / N
If so, what medication do you require? _____

_____

Have you been exposed to any **communicable diseases** within the last 6 months? Y / N
If so, please explain and indicate what medication you require _____

Do you take **recreational drugs**, or are you addicted to any drugs? Y / N
If so, please explain _____

_____

Do you have any **medical, physical or mental condition** which would not allow you to participate 100% during this camp? Y / N

If so, please explain _____

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 _____

_____

Treatment _____

_____

FOOD:
Reaction _____

_____

Treatment _____

_____

INSECT BITE / STING:
Reaction _____

_____

Treatment _____

_____

OTHER:
Reaction _____

_____

Treatment _____

_____

Please list any other health, medical or personal details, not covered above, you want us to know about:
eg. pending operations _____

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

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

_____

_____

Please specify any **dietary requirements** you have: (eg. gluten free, sugar free, vegetarian)

_____

_____

……...

Parent / Guardian Acceptance/Authorisation:

This RYPEN Seminar is conducted and supervised by Rotarians, alumni and Friends of Rotary and their partners who live in with the participants. Strict rules will be enforced to ensure the safety and well-being of each participant. Accident insurance has been taken out for the duration of the seminar. We need your approval to seek medical assistance should an emergency occur.

Please sign below to give that approval.

I, _____ give the RYPEN Chairperson permission to arrange ambulance

transport or medical attention for my son/daughter/ward, _____ , if considered necessary. I expect to be notified as soon as possible.

I agree to the above medical information provided being made available to medical practitioners if the circumstances warrant.

I give the RYPEN committee, permission to use appropriate photos of my child/children for the purposes of promoting Rotary Youth programs, and for the use on social media.

_____ Date: _____

(*Parent / Guardian)*

Please note that this application form requires the signature of the applicant, Rotary Club representative and parent / guardian before being accepted as complete.

_____

Please forward completed application form by email by 5th MAY 2019 to
Kathy Smith: kathy@chicksconqueringcancer.org
COST: $295
Payment by Direct Bank Deposit to:
Rotary International District 9640 Limited. BSB: 084 462 Account No: 796395692
You can do this via the Internet or at Your Local Bank

NB: Please indicate that the deposit is for RYPEN and

Send Copy of Receipt of Payment by email to Kathy Smith (above)

Note here with a cross (X) that payment has been made ☐

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