

APPLICATION FORM

PLEASE COMPLETE THE FOLLOWING

(ALL DETAILS WILL BE TREATED IN CONFIDENCE).

DOCTOR'S NAME:

ADDRESS:

TEL:

PLEASE GIVE US ANY INFORMATION ABOUT THE APPLICANTS HEALTH THAT WOULD BE HELPFUL FOR US TO KNOW

(I.E ASTHMA, EPILEPSY, HOMESICKNESS, BED WETTING, ETC):

PLEASE GIVE HIS/HER NATIONAL HEALTH NUMBER (ESSENTIAL):

PLEASE GIVE DETAILS OF ANY CAMP ACTIVITY IN WHICH THE APPLICANT WOULD BE UNABLE TO PARTICIPATE:

IF HE/SHE HAS A SPECIAL DIET, PLEASE PROVIDE DETAILS:

WARNING: FAILURE TO DISCLOSE IMPORTANT INFORMATION BEFORE CAMP COULD ENDANGER OTHERS AND MAY LEAD TO THE CHILD BEING SENT HOME.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE.

SIGNED (PATENT/GUARDIAN):

DATE:

IF THE APPLICANT IS RECEIVING MEDICAL ATTENTION (I.E TAKES TABLETS OR REQUIRES INJECTIONS, GIVE DETAILS BELOW, IF NECESSARY OBTAINING RELEVANT INFORMATION FROM YOU DOCTOR):

MEDICAL INFO

BOTH SIDES OF THIS FORM MUST BE COMPLETED FULLY.

CHILD'S NAME: _____

BOY

GIRL

ADDRESS: _____

POSTCODE: _____

DOB: _____

CHURCH: _____

DETAILS OF PARENT / GUARDIAN WHO WOULD BE AVAILABLE IN CASE OF AN EMERGENCY:

NAME: _____

TEL: _____

MOB: _____

EMAIL: _____

ATTENDED A BYOUTH CAMP IN 2017?

YES / NO

I WISH TO MAKE AN APPLICATION FOR THE FOLLOWING CAMP:

2ND CHOICE: _____

IF YOUR FIRST CHOICE IS FULLY BOOKED WE WILL ENDEAVOUR TO FACILITATE YOUR SECOND CHOICE. EITHER THE FULL FEE OR A £30/€35 MUST BE SENT WITH THE FORM. IN CASE OF CANCELLATION WITHIN 6 WEEKS OF THE START OF CAMP THE DEPOSIT IS NOT REFUNDABLE.

I ENCLOSE FULL FEE

I ENCLOSE DEPOSIT ONLY

I GIVE CONSENT FOR THE ABOVE CHILD TO TAKE PART IN ALL THE ACTIVITIES OF THE CAMP UNDER PROPER SUPERVISION FOR THE CAMP LEADER TO ACT 'IN LOCO PARENTIS' IN CASE OF EMERGENCY AND FIRST AID TO BE ADMINISTERED WHERE CONSIDERED NECESSARY.

SIGNED (PARENT/GUARDIAN): _____

DATE: _____