**This form is for the CYV HAF Activities 2021 only**

Please note that the information on this form is for the use Community Youth Ventures and Buckinghamshire Council and is not made available to any other 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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| --- | --- | --- |
| **Young Persons 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: |  |
| Do you qualify for free School Meals Yes/ No | | |
| Sessions requested | | |

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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: |
| 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: |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 project.
* 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.
* I agree to photos being taken of the participant, which maybe used in local publications, on our flyers or on our website to promote the work that CYV does. These images will not be used for anything which may be viewed as negative in tone or that may cause offence, embarrassment or distress for the child or family

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

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

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