



Rotary Youth Program of Enrichment

District 9640



Application Form Camp Bornhoffen 23rd to 25th May 2008

Personal Details – to be completed by applicant (please print clearly)

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 23rd May 2008): _____

WHAT SCHOOL DO YOU ATTEND? _____ WHAT GRADE? _____

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

HAVE YOU ATTENDED A RYPEN CAMP PREVIOUSLY **YES / NO** IF YES, WHAT YEAR _____

I agree that I will **NOT** smoke, use non-prescription drugs, drink alcohol or use a mobile phone while attending RYPEN. I agree to abide by the camp rules.

Awardee Signature: _____

Application Date: _____

.....
SPONSORING CLUB DETAILS – to be completed by Rotary Club

CLUB NAME: _____

ADDRESS: _____

CONTACT PERSON: _____ TELEPHONE: _____

EMAIL _____

SIGNATURE: _____ DATE: _____

Nomination fee of \$195.00 to be enclosed with application (non-refundable)

ADMIN USE ONLY:		
Paid by	RC	Other
	Diet	Health
Rec. #	_____	

Chairperson
Sandy Foote
sfoote@hillviewhouse.com.au
4/24 Brighton Street BIGGERA WATERS QLD 4216
Ph:07 5559 3204 M: 0409 067 604 Fax: 07 5522 9794

CLOSING DATE FOR APPLICATIONS: FRIDAY 25TH APRIL 2008

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

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

ADDRESS: _____
_____ Post Code: _____

PHONE home: _____ work: _____ mobile: _____

Nearest Relative

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

ADDRESS: _____
_____ Post Code: _____

PHONE home: _____ work: _____ mobile: _____

Next Contact

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)

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

Are you covered by an ambulance plan? Y / N

Any special instructions: _____

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Medical Information Do you have or have you recently had.....(please circle Y or N)

Fainting spells or dizziness	Y / N	Chron's disease	Y / N	Anaemia	Y / N
Loss of consciousness	Y / N	Cystic fibrosis	Y / N	Dislocations	Y / N
Concussion or head injury	Y / N	HIV	Y / N	Hepatitis (A, B, C, or D)	Y / N
Chronic or frequent cough	Y / N	Appendicitis	Y / N	Diabetes Mellitus	Y / N
Shortness o breath	Y / N	Arthritis or rheumatism	Y / N	Glandular Fever	Y / N
Heart disease	Y / N	Stomach trouble or ulcer	Y / N	Other (please specify)	_____
Chronic depression	Y / N	Skin disease	Y / N		

If so, please explain _____

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 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 _____

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

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

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

.....
Parent / Guardian Acceptance/Authorisation:

This RYPEN Seminar is conducted and supervised by Rotarians 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 if the circumstances warrant.

Signature _____ 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 and
cheque for payment in an envelope marked:
The District Chairperson
RYPEN
4/24 Brighton Street
BIGGERA WATERS QLD 4216**

Chairperson
Sandy Foote
sfoote@hillviewhouse.com.au
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Return no later than – 24TH MARCH 2007

Chairperson

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