## Nights Away Information Form



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| --- | --- | --- | --- |
|  | | | |
| **Event:** |  | **Dates:** |  |
| **Location:** |  | | |
| **Meeting place and time:** |  | | |
| **Collection place and time:** |  | | |
| **Cost:** |  | | |
| **Transport details:** |  | | |
| **Activities:** |  | | |
| **Further details:** |  | | |
| **Organiser and contact details:** |  | | |
| **Contact details during the event:** | PTO | | |

*Please keep this section for your own information, and detach and return the section below.*

**Note:** All activities will be run in accordance with The Scout Association’s safety Rules. No responsibility for the personal equipment/clothing and effects can be accepted by the organisers and The Scout Association does not provide automatic insurance cover in respect to such items.

✂

Please complete and return this section to       by

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of young person:** | |  | **D.o.B:** |  |
| **Event:** |  | | | |

*I enclose a cheque / cash for £**(please makes cheques payable to* *)*

I have noted the arrangements above and agree to the named young person taking part. I understand that the event Leader reserves the right to send any participants home if deemed necessary.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is he/she able to swim 50 metres and stay afloat for five minutes in light clothing? | | | Yes / No | |
| **Emergency contact:** |  | | **Phone:** |  |
| **Doctor’s name and contact details:** | | **Details of any medications currently being taken:** | | |
|  | |  | | |
| **Details of any disabilities, conditions, allergies, special needs or cultural needs that might affect this event:** | | **Details of any infectious diseases he/she has been in contact with in the last three weeks:** | | |
|  | |  | | |

*If it becomes necessary for the above named young person to receive medical treatment and I cannot be contacted to authorise this, I hereby give my general consent to any necessary medical treatment and authorise the Leader in charge to sign any document required by the hospital authorities.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |
| **Relationship to young person:** |  | | |

*Please use the back of this form if more space is required*