The Scout Association of Australia, Queensland Branch Inc.

Kennedy Region

YOUTH MEMBER INFORMATION SHEET

Form: A3
Issue: 05
Date: 02/16

Section Use	Patrol/Six:		Role:		Membership No.		Family Code	

Please complete the fields below or tick the appropriate boxes

First Name:		Middle Name:		Preferred Name:	
Surname:		School:		Gender: Male: ☐ Female: ☐	
Address:		Date of Birth:	/ /	Place of Birth:	
Suburb:		Phone:			
Post Code:		Mobile:			
e-mail :				Section:	
Mail Address:	If different from above			Start Date:	

PARENT/GUARDIAN (FATHER)		PARENT/GUARDIAN (MOTHER)	
Given Names:		Given Names:	
Surname:	as above ☐	Surname:	as above ☐
Address:	as above ☐	Address:	as above ☐
Suburb:	Post Code:	Suburb:	Post Code:
Phone Home: as above ☐		Phone Home: as above ☐	
Work:		Work:	
Mobile: as above ☐		Mobile: as above ☐	
e-mail:	as above ☐	e-mail:	as above ☐
Occupation:		Occupation:	
Interests/Hobbies/Skills:		Interests/Hobbies/Skills:	
Do you have a current Blue Card? ☐ Number:-		Do you have a current Blue Card? ☐ Number:-	

Custodial Rights:	
Father's Times:	Mothers Times:

CHILDS HEALTH CARE PLAN (IF APPROPRIATE)

If appropriate, any special needs or precautions that ought to be taken by Leaders should be outlined here. This section should be negotiated with the child's parent(s)/guardian and, if required, with an appropriate professional as well.

Suffers From:	
Allergies:	**Are Vaccinations Current**
Are any medications required? Yes☐ No.☐ If so give dosage instructions:	**Yes** ☐ **No** ☐
My child's regular doctor is: Dr	Medicare Number:
Doctor's Address:	Position on Card: Expiry Date:
	Child's physically condition? Poor Fair Average Good Excellent
Doctor's Phone: ( )	Child's swimming ability? Poor Fair Average Good Excellent

In the event of injury to the youth member, where reasonable attempts to contact me are unsuccessful I give authority for such medical treatment to be given to the youth member as is recommended by a medical practitioner and seems in the opinion of the leader in charge to be reasonable and appropriate. I undertake to be responsible for any fees or charges with respect to that treatment and to pay those costs on demand by the Association.

Name of Parent or guardian:_____________________________ **Signature:**__________________________ **Date:**__________

Please use this side of the form to elaborate and maybe remind you of any conditions your child may have or have had.

Suffers or has had the following (please tick):

CONDITION		Further Details	ALLERGIES	
Measles			Penicillin	
German Measles			Sulphur	
Mumps			Food (types)	
Chicken Pox				
Whooping Cough			Grass	
Rheumatic Fever			Bee Sting	
Glandular Fever			Insect Bites	
Diabetes			Plants	
Asthma			Other (please specify)	
Heart Disease				
Bronchitis				
Sinus				
Ear Infection				
Tonsillitis				
Heat Rash			**Other Illness** (specify below)	
Hives				
Hay Fever				
Poor Vision				
Poor Hearing				
Stomach Upsets				
Headache				
Migraine				
Constipation				
Diarrhoea				
Bed Wetting				
Excessive Bleeding				
Convulsions				
Epilepsy				
Fainting				
Anaemia				
Foot Problems				
Vertigo				

Any Special Dietary Requirements:

CONDITION		DETAILS
Coeliac		
Vegan		
Anaphylaxis		
Lactose Intolerant		