# BLUE LIGHT YOUTH LIFE SKILLS CAMP

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| **Attendee’s Personal Details** |
| **First Names** |
| **Last Names** |
| **Male** | **Female** | **Date of birth** | **Age** |
| **Street Address** |
| **Suburb**  | **Town/City** | **Postcode:** |
| **Home Phone** | **Mobile Phone** |
| **Confident Swimmer?** | **Yes** | **No** | **Ethnicity** | **Shirt Size** |
| **School/course attending** | **Email Address** |
| **Parent/Caregiver Details** |
| **First Names** |
| **Last Names** |
| **Street Address** |
| **Suburb**  | **Town/City** | **Postcode:** |
| **Home Phone** | **Mobile Phone** |
| **Relationship to attendee** | **Email Address** |
| **Compulsory for attendees to complete** |
| **What are your interests and what would you like to get out of the camp?** |
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| I declare that the information given in this form is true and complete to the best of my knowledge. I accept that the possibility of injury is inherent in the undertaking of physical activity. I will not hold Blue Light responsible for any injury or loss associated with my attending this programme. I give permission for Blue Light to take all responsible action to seek medical attention should I require it at my own expense. Blue Light regularly produces materials to profile its various programmes and services to the community. Blue Light reserves the right to use these materials which include media releases and publications. At times these materials contain stories and photos of clients. |
| **Signature:** |  | **Date signed:**  |
| **Attendee’s parent/caregiver’s signature** |  | **Date signed:**  |
| **Payment Options** | **Cost for Camp $500 inc. GST** |
| **Direct Credit** | Please Pay to ASB 12-3136-0032865-00 |
| **Credit Card Number**  | **Expiry Date** | **CVV** |
| **Name on Card** | **Cardholder’s Signature** |
| **Please return completed application with payment to:** Blue Light Ventures, P.O. Box 102-199, North Shore City, Auckland, 0745 or scan and email this form to programmes@bluelight.co.nz |

- MEDICAL IN CONFIDENCE-

Bluelight Health Questionnaire

This questionnaire is to be completed by the student or their parent/caregiver.

Please return the completed questionnaire to the coordinator

The information provided will be used to prepare a student for the programme and may be used in the event of an emergency.

M / F Age:

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Student name Student Phone Blue Light Branch

Gender

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| 1. **1. Please tick if the student has any of the following:**

□Migraine□Epilepsy□Asthma□Diabetes□Travel Sickness□Fits of any type□Recurring nose bleeds□Heart Condition□Dizzy Spells□Colour Blindness□Other - Please specify1. **Medical Alert Number**

(if **applicable)**1. **Date of last tetanus injection?**

........./........./ ......, ..1. **Is the student taking medication?**
* No
* Yes - Please state illness/s

Name of medication/sDosage & time/s to be taken**5. Outline any dietary requirements?** |  **6. Has the student had any major injuries****(breaks or strains) or illness (e.g., glandular****fever etc.) in the last six months that may limit** full **participation in any activities?*** No
* Yes - Please specify

**7. Is the student allergic to any of the following?** Prescription Medicine?  No* Yes - Please specify

Food? No* Yes - Please specify

Insect bites/stings?* No
* Yes - Please specify

Other allergies?* No
* Yes - Please specify

Treatment required?8. Tick what you are happy for us to administer if needed:□Paracetamol□Ibuprofen□Antihistamine□Habitrol□Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **9. Has the student been in contact with any contagious or infectious diseases** in**the last four weeks?*** No
* Yes - please give brief details

**10. Does the student have any skin conditions or infected wounds? This****includes exposure to fleas and/or scabies.*** No
* Yes - please give brief details

**11. Is there any other information that staff should know to ensure the physical and emotional safety of the student?** Examples: Cultural practices, disability, anxiety about heights/darkness/small places, pregnancy, behavioural/ emotional problems, mental health issues{e.g. suicidal behaviours or self-harm)* No
* Yes - please give brief details

 **13. Please tick if the student does any of the following:**□Vape□Smoke**12. Does the student have any learning difficulties (e.g. dyslexia) or ADHD?** No□ Yes - please give brief detailsStudent/Parent Name: \_ Sign: \_ Date:  |
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 Parent Name

Parent Ph

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