## Activity Information Form



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| --- | --- | --- | --- |
| ***2nd Thundersley Beaver Scout Group*** | | | |
| **Event:** | Mini hike to Woodmans Arms | **Date:** | 13th November 2015 |
| **Location:** | Hike from church hall to Woodmans arms and back again | | |
| **Meeting place and time:** | St Peters Church Hall @ 4:30 prompt | | |
| **Collection place and time:** | St Peters Church Hall @ 5:45pm approx | | |
| **Cost:** | £2 | | |
| **Transport details:** | Not applicable | | |
| **Wear / Bring:** | Full Uniform jumper . trousers scarf, | | |
| **Further details:** |  | | |
| **Organiser and contact details:** | Karen Daykin-Woodberry – 07900926187 | | |
| **Contact details during the event:** | Karen Daykin-Woodberry – 07900926187 | | |

*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.

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Please complete and return this section to Kit before 6th November 2015

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of young person:** | |  | **D.o.B:** |  |
| **Event:** | Mini Hike to Woodmans Arms | | | |

*I have noted the arrangements above and agree to the named young person taking part.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 activity:** | | **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*