## Activity Information Form



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| ***2nd Thundersley Beaver Scout Group*** |
| **Event:** | Beachcombing | **Date:** | 11th September 2015 |
| **Location:** | Canvey Thorney Bay |
| **Meeting place and time:** | Thorney Bay area mini Carpark: 4:25pm |
| **Collection place and time:** | Thorney Bay area mini Carpark: 5:45pm approx |
| **Cost:** | Nil |
| **Transport details:** | Please make own arrangements to and from the walk |
| **Wear / Bring:** | Uniform jumper & scarf, old trousers & walking shoes/boots (may get muddy) & own drink / snack whilst walking; pair gardening gloves,  |
| **Further details:** |  |
| **Organiser and contact details:** | Karen Daykin-Woodberry – 07900926187 |
| **Contact details during the event:** | Tony Greensmith - 07854810821 |

*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 Tony on the day

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| **Name of young person:** |  | **D.o.B:** |  |
| **Event:** | Beachcombing & mini Hike 11th September 2015 |

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

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| **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.*

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

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