PLYMPTON HALIFAX CALISTHENICS CLUB 2017

Name:	
Calisthenic Section:	
Class Time:	
Date of birth:	
Address:	
Email Address:	
Medicare Number:	
Medical conditions:	
Allergies:	
Family Doctor:	
Doctor's Practice:	
Doctor's phone:	
Ambulance Cover:	

Parent's/guardian's name:	
Home phone:	
Mobile phone:	
Alternate contact's name:	
Home phone:	
Mobile phone:	
Emergency contact's name:	
Mobile phone:	
Relationship:	
Date Joined :	
School attended:	
Signature (on paper copy)	

Medical notes:	Please provide details

Permissions

I consent to this information (a) being collected by (b)all or any part of this infromation being disclosed to, and (c) this information being used by Plympton Halifax Calisthenics Club Inc or any of its members for the purpose of contacting me or sending to me any information (either by post, phone or email) Yes/No

I give consent to my/my daughter's photo (not name) being used for promotional purposes Yes/No

When neither parent nor emergency contact named on this form can be contacted, I give permission for the appropriate action to be taken Yes/No