The Boys' Brigade Western Australia Inc.

training tomorrow's leaders today

Membership Application Form 2020

BBWA Form R1.0

This Application is for	First Name	Surname		
3rd Morley	7th Bull Creek	9th Riverton	10th North Beach	13th Geraldton
16th Canning Vale	20th Gosnells	26th Eastern Hills	32nd Goldfields	41st Dale

General Information

Home Address	Home Phone	Street Address			
	Suburb	Postcode	State		
Emergency Contacts: (Not Living at Same address)	Name	Relationship	Mobile Phone		
	Address	Suburb			
Parents or Caregivers	First Name	Surname	M/F	Mobile Phone	Email Address
	First Name	Surname	M/F	Mobile Phone	Email Address
Boy's Details	First Name	Surname	Date of Birth dd/mm/yyyy		
	School Year	School Attending	Church Attending		

Helpful Information

Aboriginal/Torres Strait Islander	No	Yes		
Country of Birth	Australia	English Speaking	Other	
Main Language Spoken at Home	English	Other		
Dyslexia	No	Low	Med	High
Autism	No	Low	Med	High
ADHD	No	Low	Med	High
ODD	No	Low	Med	High
Anxiety	No	Low	Med	High
Depression	No	Low	Med	High
Medicare Number	Main Number	Reference Number		
Private Medical Insurance	Name of Insurer	Policy Number		
Doctor's Name	Medical Centre	Phone		

Medical Details

If any response below is "Yes" please complete the Medical Management Plan overleaf.

	No	Yes	Details & Comments
Food Allergies			
Allergies (Anaphylaxis)			
Asthma			
Cystic Fibrosis			
Diabetes			
Epilepsy			
Haemophilia			
Heart / Blood Problems			

Other medical conditions and information	
Details of any recent operations, illnesses or injuries:	

Medication

Has person approval for self-administration of medication?	**No**	**Yes**	**Routine**	**Emergency**

Prescription Medications: [Note: All medications MUST be in their original container showing pharmacy label]

Drug Name	Dosage	Frequency / Times	Doctor's Instructions	Routine	Emergency

In the event of headache, coughs or colds, the following pharmacy medications may be used:

Panadol	No	Yes		Nurofen	No	Yes	Other	Other

I declare that the information on this form is complete, correct and is based on advice provided by a medical practitioner and request that the medication as specified on this form be administered, or assistance be provided in the management of the medication, in accordance with the instructions provided.

Signature: ..... **Relationship to Person:** .....

Print Name: ..... **Date:** ...../...../.....

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Emergency Medical Conditions Leave blank if not required

Emergency Medical Conditions

Description of the condition			
What may trigger a medical emergency? (food, exercise, environmental stimulus, etc.)			
What can be done to prevent or reduce the chance of a medical emergency? [eg. limitations or guidelines for specific activities]			
What are the reactions, warning signs and symptoms of a medical emergency? (rash, swelling, pain, etc.)			
Is the reaction local (affecting only a small area) or general (affecting different parts of the body)?			
Is the condition life threatening?		**No**	**Yes**
In the past, has a reaction resulted in the obstruction of airways, or an anaphylactic reaction requiring the administration of Adrenaline?		**No**	**Yes**
Critical Response time: Some older groups may undertake activities involving a high level of physical activity in isolated locations where an emergency response time could exceed 2 hours. **Is it safe for the participant to undertake such activities?**		**No**	**Yes**

Emergency Action

Does the condition require the administration of medication or injection?		**No**	**Yes**
Do you carry the medication required to prevent or treat the condition?		**No**	**Yes**
Drug Name	**Dosage and details of administration** (when and how medication is given)		
Detailed Plan of First Aid Treatment Below: OR I have provided a separate document provided by a medical practitioner.		**No**	**Yes**
Step 1:			
Step 2:			
Step 3:			
Step 4:			
Step 5:			
Step 6:			

If the form above is blank, no emergency medical information is required

This page must be signed below

I declare that the information on this form is complete, correct and is based on advice provided by a medical practitioner and request that the medication as specified on this form be administered, or assistance be provided in the management of the medication, in accordance with the instructions provided.

Signature: ..... **Relationship to Person:** .....

Print Name: ..... **Date:** ...../...../.....