Medical Disclosure

Do you have any medical conditions we may need to know about? No | Yes

If 'yes' please provide details: _____

Have you had any serious injuries that may affect you? No | Yes

If 'yes' please provide details: _____

Do you suffer from any allergies? No | Yes

If 'yes' please provide details: _____

Do you have any special dietary requirements? No | Yes

If 'yes' please provide details: _____

Is there anything that we should know about you? No | Yes

If 'yes' please provide details: _____

Are you on any medication? No | Yes

If 'yes' please bring this with you and give to the Facilitator

Medical Consent

In case of severe allergic reaction to a wasp/bee sting, I give permission for the Facilitator/ Coordinators to supervise the self-administration of antihistamines to my tamaiti/tamariki.

Participants Consent

I understand that there are risks associated with activities in the outdoors. I am aware that the Facilitator/Coordinators will take all reasonable steps to manage these risks to an acceptable level and to set appropriate safety standards.

Participants Signature: _____

Date: _____

Parent /Guardian/Caregiver Signature: _____

Date: _____

Please return this completed and signed registration via email to angie@taranaki.iwi.nz