VALLEYS GYMNASTICS ACADEMY

COACHES / VOLUNTEERS PARTICIPANT DETAILS

Office Use Only

INSURANCE No

Qualification Level ***(please circle)***

ASST coach L1 L2 L3 L4 L5 Other- Please state below

PERSONAL AND CONTACT DETAILS

MEMBER SURNAME

MEMBER FORENAME

ADDRESS

POST CODE

DATE OF BIRTH D D M M Y Y Y Y

Sex: Male / Female **(please circle)**

CONTACT HOME NUMBER

MOBILE NUMBER

EMAIL ADDRESS

EMERGENCY CONTACT NAME

EMERGENCY TELEPHONE

RELATIONSHIP TO MEMBER

MEDICAL HEALTH INFORMATION

Please give details of any medical condition or health needs that the club should be aware of: ***(use overleaf if needed)***

.....

Please give details of any allergies:.....

.....

Please give details of any special dietary requirements:.....

GP Name:..... **GP Tel:**.....

MEMBER CONSENT

I confirm that I have completed the section on medical details and give consent that in the event of any illness/ accidents the necessary first aid treatment can be administered. In signing this agreement I declare that I have read the Code of Conduct.
I am aware that if Valleys GA funds any courses or exams that I attend and I terminate my position within 1 year of the course /exam being taken I will be obliged to reimburse the full costs to Valleys GA.
I am aware that if any personal details change, I must inform Valleys GA immediately.

Member Name:**.....**

Member Signature:**.....** ***Date:*****.....**